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UNIVERSITY OF ALBERTA

DEVELOPING TRUSTING RELATIONSHIPS: HOME CARE NURSES AND ELDERLY CLIENTS

BY

LORRAINE TROJAN

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

AND RESEARCH IN PARTIAL FULFILLMENT

OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF NURSING

FACULTY OF NURSING

EDMONTON, ALBERTA

SPRING, 1992

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Lorraine Trojan

(Student's signature)

4324-116 Street,

Edmonton, Alberta, T6J 1R9.

Date: Nov. 8/91

UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled "Developing Trusting Relationships: Home Care Nurses and Elderly Clients" submitted by Lorraine Trojan in partial fulfillment for the degree of Master of Nursing.

Olive Yonge

Supervisor, Dr. O. Yonge

Anne Neufeld

Dr. A. Neufeld

Donna Kay

Dr. D. A. MacKay

Date: Oct 11/1991

Abstract

The development of the trusting relationships between home care nurses and elders is an important focus for research. The essential research question for this study was 'What is the nature of forming trusting relationships?' The two other questions that stemmed from the initial question are as follows: (1) what is the process of developing a trusting relationship between home care nurses and elderly clients; and (2) what factors interfere with or promote the development of this relationship? Data was obtained from seven home care nurses and six elderly clients who were interviewed from one to three times. The data was analyzed using grounded theory methodology and sorted using Microsoft Word Processing on a Macintosh computer. Nurses and their elderly clients perceive trusting relationships differently. Nurses' trust of their clients is expressed in terms of (a) respect, (b) compliance or noncompliance with what was negotiated, and (c) trust to express what is needed from the nurse. The overall theme which was identified in the data was labeled 'trusting, caring relationships.' This theme encompasses trusting which is developed and the caring which the nurses provide. The four phases in these relationship are (a) initial trusting, (b) connecting, (c) negotiating and (d) helping. Nurses and clients identified the following factors which can facilitate or interfere with the development of trusting relationships: length of time in home care; having the same nurse; the identity of the initial nurse; the client's needs; the client's personality; the nurse's personality, skills, experience and priorities; the client's gender; the client's culture; the nurse's relationship with physician; other services; and referral to home care. The findings from this study have implications for nursing practice, administration and education. More nursing research needs

to be done on trust in different contexts to assist all nurses in establishing therapeutic nurse-client relationships.

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CHAPTER I: INTRODUCTION

In Alberta there are 200,000 elders (Senior Citizens Secretariat, 1989). As there has been a steady increase in this population, the demand for health care services has also increased. In particular, the demand for home care services has become greater and funding for these services has substantially expanded in the past four years. Elders tend to have more health problems and chronic conditions than younger individuals. Each year home care nurses see approximately 17,000 elders, who make up 93% of the nurses' caseloads (C. Burton, Alberta Health, personal communication, June 1990). These elderly clients prefer to live at home as long and independently as possible.

The provincial government's recent hospital funding proposals have also had an impact on the elderly clients and home care. Since funding for hospitals is being restricted, hospital beds are being closed and admission into hospitals limited. Thus more sick patients are cared for in their community (Sherlocke, 1990). This trend increases the home care nurses' workload.

For home care nurses to provide nursing care that is beneficial, they must form effective nurse-patient relationships with their clients. Trust is considered an essential component of the nurse-patient relationship (Chitty & Maynard, 1986; Ruditis, 1979; Thomas, 1970). Since the home care nurses see many elders, trust in the home care nurse-elderly client relationship is important. However, home care nurses identify some of their clients as being difficult to care for. Thorne & Robinson (1984) indicated that difficult patients such as those who were demanding, angry, manipulative or uncooperative may not have trusted their health care providers. Trust in the nurse-patient

relationship has not been extensively examined (Morse, 1990) and trust in specific areas of nursing such as home care and gerontology have not been studied. The purpose of this study, therefore, was to examine the development of trusting relationships between home care nurses and elders and to investigate the factors that interfered with or promoted this relationship.

The findings from this study are important to home care nurses, their clients, and the administrators of home care services. The results of this study will assist nurses in examining a component of relationship building which may influence the quality of care provided to their clients. The findings can also be applied directly in the practice of nursing and in education to improve nurse-client relationships. For example, if the way a client is taught a self-care technology affects the client's trust of the nurse, implications for the selection of teaching strategies emerge. The findings about trusting relationships have implications for the improvement of elderly clients' satisfaction with care (Thorne & Robinson, 1988b; Distefano, Garrison & Pryer, 1981), as well as their health and self-esteem.

This study investigates trusting and its outcomes and should increase nursing knowledge in caring, trusting and nurse-patient relationships as the areas are related. Research in the area of gerontology and home care is also essential at this time because the number of elders is steadily increasing and there is a trend of more patients being cared for in their community. Outcomes from this study may have implications for home care administration in defining standards of care and evaluating competence of home care nurses. The information collected from the elderly clients may also have implications for the empowerment of clients. Research in this area will assist the nurses in providing quality care to their elderly clients.

Key Terms

Trust: an attitude bound by time and space in which one relies with confidence on someone. Trust is also characterized by its fragility (Meize-Grochowski, 1984);

Elder: a person over 60 years of age;

Home Care: nurses visit clients in their homes and provide nursing care to them such as dressing changes and injections.

Research Questions

Trust has been identified as an important component of the nurse-patient relationship (Morse, 1990; Ruditis, 1979; Thomas, 1970), but nursing research on this topic is not extensive. Also, trust in specific areas of nursing practice such as home care and gerontology has not been examined. Scales that have been developed on trust focus on hospital patients and do not adequately measure the trusting relationships between the nurses and clients. Also, elders at home can relate differently to their nurses than elders in the hospital. The development of the trusting relationships between home care nurses and elders is an important focus for research. The essential research question for this study was 'What is the nature of forming trusting relationships?' The two other questions that stemmed from the initial question are as follows: (1) what is the process of developing a trusting relationship between home care nurses and elderly clients; and (2) what factors interfere with or promote the development of this relationship?

Chapter II: Review of the Literature

Trust is a topic which has been discussed in the nursing literature; however, there are few nursing studies that focus on trust. The two scales that have been developed to measure trust in a nurse-client relationship have not been utilized because their validity has been minimally tested and is uncertain.

Trust is related to the concepts of dependence, belief and hope, but it has some different attributes. For example, dependence is defined as an inability to act for one's self while relying on another (Webster, 1986). In trust, however, there is an option to choose to trust or mistrust. In belief there is an acceptance of what is given to you. Acceptance, however, is not an attribute of trust. Hope is also similar in that there is an expectation and a desire for a certain event to occur. In hope one may not have confidence in the event occurring but in trust one has confidence in someone or something.

The literature review for this study covered nursing research and trust; nursing literature and trust; nurse-patient relationships; psychology and trust; and elders and home care. Since there are many gaps in the nursing literature on this topic, this literature review has a broad focus.

Nursing Research and Trust

The research that has been done in nursing indicated that trust is an essential component of the nurse-patient relationship. Thorne and Robinson (1988a, 1989) used grounded theory methodology to identify the stages that patients with a chronic illness go through to develop relationships with their physicians. These stages included naive trust, disenchantment, and guarded alliance, which is a reconstruction of trust. During disenchantment the patient

or the family became dissatisfied with the care provided, so the patient became difficult or the family interfered with the care. Their theory, however, was derived from physician-patient relationships, so trust in nurse-patient relationships may develop differently. In a study on commitment and involvement in the nurse-patient relationship, Morse (1990) identified two types of patient trust: immediate trust in the nurse's technical competence and a later development of interpersonal trust. She described the following four types of relationships that a nurse has with a patient: clinical, normal, connected and overinvolved. Morse's (1990) study, however, looked at nurse-patient relationships in all areas of nursing, and does not focus on trust specifically and the factors that interfere with the development of the trusting relationship. Also, trust in specific areas of nursing such as home care and gerontology have not been examined.

Robinson and Thorne (1988b) described reciprocal trust as the patient's trusting the health care professional, and this professional also trusting the patient. If the physicians trusted the patients, the patients stated that their self-esteem improved and they were satisfied with the relationship. It is questionable though, whether reciprocal trust is similar in a nurse-patient relationship. Morse (1990) identified 'not trusting' as strategies used by both the nurse and the patient to inhibit their involvement in the nurse-patient relationship. For example, the nurse may suspect that the patient has ulterior motives, while the patient becomes demanding or coercive. Morse (1990) also questioned whether the following two factors interfered with trust development: nurses not getting the same assignment and thus the patients not getting to know the nurses, and nurses having to chart the patients' self disclosures and all the staff knowing the patients' feelings. Nurses who do not have frequent changes of clients such as the ones in home care may

view the development of trust differently. As well, patients in the hospital may experience trust differently than those in the community.

In another study using grounded theory methodology, Chenitz (1983) studied the passage of elders into a nursing home. She indicated that elders went into a crisis after they entered a nursing home. Some elders resisted the admission by never adjusting, and manifested behaviors such as becoming angry, withdrawn, hostile, tearful and depressed. Chenitz's (1983) study supported the need for home care services so elders can stay at home with support for a longer period of time and avoid entering the nursing home. She concluded that trust in the nurse-patient relationship after the patient was admitted was a necessary factor before any nursing intervention could succeed. Trust is therefore an important concept for elders that needs further study.

The findings from two other studies which identified trust as being important in patient-health professional relationships differ. In a descriptive study of nurses and rehabilitation patients, Keane, Chastain and Rudisill (1987), using the Care-Q instrument, obtained perceptions of important nurse caring behaviors. Both patients and nurses ranked the following behaviors as the most important: [the nurse] 'knows when to call the doctor' and 'monitors and follows through'. For the patients, demonstrated competency of skills and accessibility preceded a trusting relationship. These characteristics were different from what the nurses predicted. In a retrospective interview-based study, Bergbom-Engberg and Haljamae (1988) assessed patients' experience and feelings of security or insecurity while receiving respirator treatments. They concluded that feelings of insecurity were mainly caused by communication problems, inadequate information and lack of trust in the nursing staff rather than by respiratory care related

activities. The following significant question arises from these two studies and needs to be addressed: 'Does a nurse's competency in nursing skills facilitate the development of a trusting relationship with her or his patient?'

Nursing Literature and Trust

Previously, nurses have written about the importance of trust (Travelbee, 1971). Ruditis (1979) stated that patients and nurses do not easily develop trusting relationships. The nurse had to be consistent and trustworthy as well as motivated to develop this relationship. Patients with unhappy interpersonal relationships tested nurses by rejecting them before the nurses established therapeutic relationships (Mitchell & Loustau, 1981). Meize-Grochowski (1984) identified the following antecedents of trust: consistent behavior by the nurse and the patient's having a previous positive association with the nurse or nursing. The consequences of trust are a sharing of feelings and an openness or honesty between the nurse and the patient. References to consistency and positive association are theoretical positions and have not been validated through research.

Nursing Trust Scales

Risser (1975) developed an instrument to measure patient satisfaction with nurses and nursing care. Although one of the subscales which measures the trusting relationship was based on data from interviews, it has only been used once (Ventura, Fox, Corley & Mercurio, 1982). The author felt that Risser's instrument did not measure the trusting relationship accurately because it is not sufficiently sensitive to pick up the presence of trust, pertained only to ambulatory patients in a hospital setting, and did not contain all the factors interfering with the development of trust. The Nurses'

Trust of Patients' scale (Wallston, Wallston, & Gore, 1973) which had never been used in research, also, appeared questionable because of its bias. For example, one item stated 'most nurses like to gossip with each other about their patients'. The scale developed to measure trust in the nurse-patient relationship was not valid or adequate.

Nurse-Patient Relationships

May (1990) reviewed the literature on nurse-patient relationships to find the literature was very extensive ranging from what nurse-patient relationships ought to be to the realities of nursing practice. Nursing research indicated that nurses generally delimit and control verbal interaction. For example, nurses spend little time in verbal communications with patients and the interaction which occurs tends to be superficial and task oriented.

Another study focused on nurse-client interactions in community-based practice (Kristjanson & Chalmers, 1990). The clinical situations which were videotaped and analyzed were home visits, school health, health classes, and clinical work. "Creating common ground" was identified as the central theme. The process depended on the nurses' skills, care context and the clients' willingness to interact with the nurse. Although many of the studies on nurse-patient relationships do not identify trust, the themes in these studies may be similar to those in trusting nurse-patient relationships.

Psychology and Trust

Psychologists have written extensively about and researched trust. Erikson (Smart & Smart, 1972) was one of the first psychologists to stress the importance of trust. He determined that an infant needs to develop a sense

of trust in the first year of life. Trust development is enhanced by the mother providing consistent loving care. Infants developed mistrust if their mothers did not meet their needs. If infants trusted their guardians, the infants developed healthy personalities.

Consequently, there are a number of definitions of trust (Giffin, 1967; Pearce, 1974; Rotter, 1967; Wheeless, 1978). Interpersonal trust in the communication process is defined as reliance upon the communication of another person to achieve a desired but uncertain objective in a risky situation (Giffin, 1967). Rotter (1967) defined trust as an expectancy held by an individual or a group that the word, promise, verbal or written statement of another individual or group can be relied upon.

A few scales have been developed to measure trust, but Rotter's (1967, 1971, 1980) Trust Scale has been widely used, mostly on surveys of college students. For example, Kaplan (1973) administered Rotter's Trust Scale to 97 college students and found that this scale had the following components: trust toward institutions, perceived sincerity of others and the need to be cautious of others. Rotter (1971) found a strong relationship between high trust and trustworthiness where students who acted more trusting or said they are more trusting were themselves less likely to lie. He also concluded that a high truster is less likely to be unhappy, conflicted or maladjusted. The following criticisms have been cited about Rotter's (1967) scale: (1) it does not measure trust in specific individuals, but rather trust in general (Wheeless, 1978; Luster, 1984); (2) it has both masculine content sex bias and grammatical sex bias (Wright & Sharp, 1979); and (3) there is an incongruity between Rotter's definition and his measure of interpersonal trust as trust is a multidimensional construct (Chun & Campbell, 1974; Corazzini, 1977).

Other researchers also developed or validated instruments on trust. Deutsch (1961) investigated the determinants of trusting behaviors and found that subjects who were trusting were also trustworthy and subjects who were suspicious were untrustworthy. Scott (1980) suggested that Giffin's (1967) saw interpersonal trust as an attitudinal factor while Rotter considered interpersonal trust as a situational variable. Scott (1980) demonstrated that both attitudinal and situational factors were present in interpersonal trust scores. Wheeless and Grotz (1977) devised a semantic differential-type scale which measured trust in specific individuals and concluded that varying degrees of disclosure are related to varying degrees in perceptions of trustworthiness. A specific interpersonal trust scale was constructed and validated to measure an individual's trust in a specific other person (Johnson, George & Swap, 1982).

Other researchers used Rotter's (1967) scale. Distefano, Pryer and Garrison (1981) surveyed patient satisfaction in a psychiatric hospital and concluded that patient satisfaction correlated with Rotter's Trust Scale. Schill, Toves and Ramanaiah (1980) studied whether interpersonal trust moderated effects of life stress. In their survey they found that subjects who scored low in trust had higher stress scores and reported more emotional and physical distress. People who felt powerless were less likely to trust others.

Rotenberg (1990) modified Rotter's trust scale to measure trust beliefs of elderly individuals to find that there was a complex relationship between trust and income. From this sample of 140 elderly individuals, Rotenberg (1990) found that individuals with lower incomes placed their trust in specific groups rather than in social-legal organizations and had a fear of crime. Younger-old age persons also tended to have more trust in social-legal

organizations than middle-old age persons. This study produced interesting results, but did not focus on trust in nurse-elderly client relationships.

Nurses have also used Rotter's (1967) scale. Beard (1982) looked at the relationship between interpersonal trust, life events, and coronary heart disease risk factors. Although she found significant relationships, the limitation of her study was her convenient, nonrandom sample. Luster (1984) used quasi-experimental design on eighty postpartum subjects to study the effects of team nursing and total patient care on the subject's interpersonal trust. Significance was not established between the types of care and the trust scores. Luster (1984) concluded that Rotter's scale measured general trust and could not specifically measure patient's trust of the nurse. Luster (1984) recommended the development of an instrument that would specifically measure patient's trust in nurses.

The scales developed in psychology were not suitable for this nursing research project (Rotter, 1967; Wheeless & Grotz, 1977; Johnson, George & Swap, 1982). Nurses work in a different context than therapists as nurses see clients in their homes and provide a broad range of services. The scales which have been developed do not specifically measure patient's trust in nurses.

Elders and Home Care

Research on elders and home care is limited. Most of the research pertains to caregivers (Phillips & Rempusheski, 1986, 1988), administration of home care services (Martin, 1988), quality assurance (Phillips, Applebaum & Atchley, 1989), aging (Boyle & Counts, 1988) and health assessment (Runciman, 1989). Some studies indicate that there is an increasing need for home care services as the number of frail, elderly people is increasing

(Waters, 1987; Ahroni, 1989) with their caregivers becoming elderly themselves or not having the resources to provide long-term, continuous care (Folden, 1990; Van Ort & Woodtli, 1989). The studies that focus on trust in the nurse-elderly patient relationship are scant (Golander, 1987). Weinrich, Boyd & Nussbaum (1989) discussed the need to adapt strategies to teach the elderly, but did not address the nurse-elderly patient relationship which is crucial to successful learning and teaching.

Elder's perceptions of home care were addressed in an ethnography (Magilvy, Brown & Dydyn, 1988). The three themes that influence the elder's perceptions are nursing care, health problems and independence. Home care was initially perceived as being helpful, but as the patients started to feel better and began to undertake self-care, home care was perceived as supporting dependence. This study described the elder's meaning of home care, but did not provide nurses with the needed information to guide nursing practice nor did it address the nurse-elder relationship.

Some of the research that has been conducted on elders identified trust as being an important component in the nurse-elderly patient relationship (Abbott, 1989; Beard, 1982; Chenitz, 1983; Gelperin, 1973; Magnan, 1989). Also, elderly patients portrayed feelings and emotions of distrust by becoming difficult patients because they perceived themselves as having lack of power and control over their situation (English & Morse, 1988). Because home care is a relatively new area of nursing in this province, research on the elderly and home care has not been extensive. Trust in elderly individuals has been ignored in the literature (Rotenberg, 1990). Since home care nurses play a major role in the care of elders and trust has been identified as being important, a study of trust in home care nurse-elderly client relationships was needed.

CHAPTER III: METHOD

Introduction

Since trust in nurse-patient relationships had not really been examined, qualitative descriptive methodology was more appropriate to answer the research questions. This design facilitated the discovery of the nature of trust and the process of developing trusting relationships from the nurses' and elderly clients' perspective. The grounded theory approach was employed to determine the informants' meaning of trusting relationships and their perspective on the development of these relationships.

Grounded Theory

Grounded theory was developed by symbolic interaction theorists who view human behavior as being part of a social process (Glaser & Strauss, 1967). Grounded theory is the discovery, development and verification of data which has been systematically collected and analyzed. In grounded theory, an area of study is chosen and data relevant to that area is allowed to emerge rather than verifying an existing theory (Strauss & Corbin, 1990). It involves both an inductive and deductive approach to theory construction in that constructs and concepts are grounded in the data and hypotheses are tested as they arise from the data (Field & Morse, 1985). The purpose of grounded theory method is to build theory that illuminates the area under study (Strauss & Corbin, 1990).

Data Collection Methods

Informant Selection

This study was conducted in a Western Canadian city. Home care administration initially informed the nurses about this study, then invited the researcher to explain the study to the nurses at an inservice. The home care nurses who were interested in participating in the study gave their names to the researcher at the meeting or called her later. The nurses approached appropriate clients about participating in the study. The administration in this health care facility thought that the nurses would be the best client advocates. The nurses informed clients about the study and asked if they were willing to have their name given to the researcher who would contact them. The names of the clients who were interested in the study were given to the researcher. The criteria for the selection of informants, both clients and nurses, were as follows: able to verbalize thoughts and feelings, able to speak English fluently and willing to participate in this study. From these informants it was anticipated that the researcher would get an understanding of the different stages of trusting relationships from both the clients' and nurses' perspectives as well as some negative cases. It was also anticipated that there would be difficulty (a) identifying experts in this area because trusting relationships were not clearly defined and (b) attracting informants who were considered negative cases.

The interviewing stopped when all the informants who were willing to participate were interviewed and the data from the interviews was being duplicated. Because of the vast amount of data collected and financial and time restraints, more informants were not sought. With this small sample there was a saturation of data (Glaser & Strauss, 1967). Some of the informants were shown the findings and the emerging model near the end of

the study and invited to assist the researcher in validating the results (Field & Morse, 1985).

Sample

There was a total number of thirteen informants participating in this study, seven home care nurses and six elderly clients. Two home care nurses, friends of the researcher, volunteered for a pilot study. The other five home care nurses and six clients were from a health unit serving a large town and a rural area outside a metropolitan area. The researcher was unable to recruit any elderly home care clients to participate as pilots for this study.

The seven female home care nurses had different experiences and education. Four of the nurses were in their 30's, one was in the 40's and two were in their 50's. Three of the nurses had 5 years of experience while the others had 10 or more years. Home care services in the province started in 1976, and some of the nurses worked in pilot projects prior to that time. Three nurses had their BScN, and four had certificates in Gerontology. One of the nurses in the pilot study worked for a city health care agency while the other one worked in a rural area.

The six elderly clients and two spouses who participated in this study were being cared for by two nurses who were also interviewed. All of the clients were over sixty years of age. Three of the clients lived in a lodge in one of the communities while the others lived in their own homes. The clients occupations include farmer, coal miner, chef, secretary or store clerk. One of the clients had received home care services for a number of years from two agencies. Two of the clients were on home care for two years while another two received services for one year. One client was in the program for only a few months. Two of the clients were male and their wives also participated in the interviews. There was another couple who received home care but

the husband was not interviewed because he had Alzheimer's. The other three clients were women who resided in a lodge because of their health. These clients came from different backgrounds, had a variety of health problems and had received home care services for different periods of time (Table I). The names given to the nurses are fictitious.

Data Collection

In October, 1990 the researcher started interviewing the home care nurses who participated in the pilot study and in May, 1991 all the interviews were completed. Interviews lasted approximately one hour, and each informant was interviewed one to three times. Two of the home care nurses were interviewed three times while four of them were interviewed twice and one was seen once. Three of the clients were interviewed twice while the

Table III-1

Description of the Elderly Clients Who Were Interviewed

Clients	Gender		Length of H.C. Services	Family Support	Other Services	# of times seen
	Male	Female				
1		X	2 yrs	yes	homemaker	3
2	X	X	2 yrs	yes	homemaker	1
3	X	X	1 yr	yes	none	2
4		X	many yrs	yes	none	2
5		X	few months	no	none	1
6		X	1 yr	no	none	1

others were interviewed once. In addition, three validation interviews were done with two nurses and with one client. All the interviews, with the exception of two from the clients, were audiotaped and then transcribed. One client said her voice was too squeaky while the other said she may say something she would regret later. One of the nurses also kept turning off the recorder when she wanted to say something which she did not want recorded. After the interviews, field notes were written describing the clients' nonverbal behaviors and the setting. A diary captured the researcher's subjective impressions of her feelings about the experience.

To collect the data the researcher used several open-ended questions with each informant and observed the informants. What the informants described as their experience was viewed as being valid. By using open-ended interviews, the researcher explored the topic with the informants. The first interview focused on making the informants as comfortable and relaxed as possible. The informants were asked a few questions pertaining to biographical data (Appendix E). Examples of open-ended questions that guided some of the interviews are included in Appendix A. Other questions were developed as the data analysis progressed and the relationships within the data were identified (Field & Morse, 1985).

Data Analysis

Using grounded theory methods, the initial phase of the analysis began by coding the data from the researcher's observations and the interviews. The purpose of the data analysis was to code the data so that the categories can be recognized and developed, and the behaviors noted (Field & Morse, 1985). The Macintosh computer and Microsoft Word software were used in the analysis of the data (Morse, 1990). A secretary had transcribed

the interviews from the audiotapes. In addition to reviewing and commenting on the data, the researcher identified concepts in each interview. Using multiple windows, files for each concept were created and the data relating to the concepts along with informant and interview numbers were copied from the interview file to the concept file. Memos were also kept of this process as categories and relationships were emerging. The constant comparisons of the data that are needed in grounded theory could be made using the multiple windows.

Categories were developed from the concepts and data collected until the categories appeared to be saturated and no new information was forthcoming (Field & Morse, 1985; Strauss & Corbin, 1990). During the writing process the files containing the concepts were used extensively. The analysis also focused on the interrelationships between the categories, and the connection between the categories and the existing theories. Hypotheses were tested and specific data sought so saturation of the categories would occur. Data from the validation interviews also increased and clarified the data. A core category which encompassed the initial categories was identified. A theoretical framework was developed from the data the informants provided which explained the meaning of a trusting relationship for the elderly clients and home care nurses (Field & Morse, 1985; Strauss & Corbin, 1990).

Reliability and Validity

Grounded theory methodology generates theory rather than verifying it. Reliability and validity is thus addressed differently in qualitative research than in quantitative research (Field & Morse, 1985). There was a focus on validity during data collection and analysis (Field & Morse, 1988). Informants

who are willing to participate and able to express their feelings were selected. The clients were interviewed in their homes while nurses were interviewed at a location of their choice, which were mainly their offices. The informants' thoughts and feelings were viewed as being valid regardless of the content expressed. The informants were asked for biographical information to determine if there were differences in their backgrounds. A diary was kept by the researcher to record her actions, interactions and subjective states in the field as well as changes in behaviors and attitudes (Chenitz & Swanson, 1986). To increase the validity of this study two nurses participated in preliminary interviews. The data from these interviews were analyzed and reviewed by the researcher's advisor to detect strengths, bias and future direction. The researcher was not successful in recruiting elder clients to serve in the pilot study.

Detailed descriptions of the data and the elders were provided so readers of the study could review it to see if the grounded theory is generalizable to their group (Chenitz & Swanson, 1986). Generalizability is not the purpose of qualitative research (Field & Morse, 1986), however the essence of grounded theory can be generalized to some elders receiving home care services. The range and variation of informants who volunteered to participate improved validity. Negative cases not fitting into existing categories were also included to increase validity (Chenitz & Swanson, 1986).

Reliability is a constituent element of validity (Field & Morse, 1985). The researcher who is doing this study had previous experience in interviewing. She established rapport with the informants and kept field notes. Having the interviews audiotaped, and then transcribed verbatim increased reliability. Both groups of informants were asked questions that

focused on the development of trusting relationships. Guiding questions had been identified, but were changed as the data analysis progressed. Some informants were shown the findings and the emerging model near the end of the study to see if they agreed (Field & Morse, 1985). The findings from grounded theory may be useful to clients and nurses in similar situations.

Bias

The researcher was aware of the effects of bias, since she has previously worked with elders. Personal values were bracketed as much as possible. The researcher engaged in self-reflection by writing daily in her diary. The researcher's advisor also assisted in detecting and clarifying any bias the researcher may have had by questioning transcripts. The informants were encouraged to give honest feelings about trust in the nurse-patient relationship. The researcher attempted to be nonjudgemental and to present herself as a researcher with no connection to home care so that the informants would feel safe in disclosing sensitive information. The researcher was vigiliant to extraneous factors that may place her in a position of authority thereby forcing the interview. The researcher was able to focus on her research rather than her nursing experience. There were times, however, when the researcher felt she could understand what the informants were saying because of her previous nursing experience.

Ethical Considerations

This proposal received ethical clearance from the Faculty of Nursing's Ethics Review Committee and from the home care agency. The administrators of home care contacted the nurses. Written consents were obtained from all informants after the study was explained to them (Appendix

B & C). All informants in the study spoke English. For those informants who could not read, the consent form was read to them, and a verbal consent was obtained on a separate tape. Participation by the informants was voluntary and they could withdraw from this study at any time. The client's care was not affected because of their participation in this study.

Confidentiality and anonymity of the individuals and confidentiality of the agency were maintained. The names, addresses and telephone numbers of the informants were known only to the researcher. The interviews were assigned a code number, and any identifying information was erased, so the informant's anonymity would be preserved. The names, addresses and code numbers were kept separate from the data in a locked cabinet to be destroyed at the end of the study. The data from the interviews was kept in a separate locked file and made available only to the secretary for transcribing or the researcher's advisor for reading. If the data is used for secondary analysis at a later date, prior approval from an ethics committee will obtained at that time. The transcriber of the audio recording was also be required to sign an oath of confidentiality (Appendix D) to provide extra protection for the informants.

The risk to the informants was minimal. The researcher was sensitive to the informant's emotional state. There were no health concerns expressed by the informants which had to be referred to the home care nurse. There are implications from the finding of this study for the formation of nurse-client relationships, promotion of client independence and the provision of nursing care.

CHAPTER IV: FINDINGS

Introduction

The results of the data analysis are presented in this chapter . Using the grounded theory approach (Strauss & Corbin, 1990), categories emerged relating to the nature of trusting and the process of developing trusting relationships. The nature of trusting, the process of developing trusting relationships, and the factors which interfere with or facilitate the development of these relationships are discussed.

Nurses and their elderly clients perceive trusting relationships differently. Nurses' trust of their clients is expressed in terms of (a) respect, (b) compliance or noncompliance with what was negotiated, and (c) trust to express what is needed from the nurse. There were also a few examples of nurses not trusting their clients. Many elderly clients initially trust their nurses because nurses receive extensive education and work in the health care system. They believe that trust is essential to nurse-patient relationships and expect nurses to have a certain trust in them. Conversely, nurses feel that it is important for clients to trust them.

Nurses elaborated on the process of developing trusting relationships with their clients. Clients expressed the qualities they welcome in nurses, how they work with them, and how nurses help them. The overall theme which was identified in the data labeled 'trusting, caring relationships', had four phases: (a) initial trusting, (b) connecting, (c) negotiating and (d) helping. Clients identified connecting as getting to know the nurse, and negotiating as working together. Nurses and clients used the term "helping" to describe nursing actions.

The Nature of Trusting

The study's informants reside in towns in a rural area where people tend to be more trusting because they know about community members' reputations. Community members and services have been dependable, reliable, and safe in the past; thus, there exists an element of social trust. This social trust would initially influence home care nurses' relationships with their elderly clients; indeed, the social trust appeared to be relatively strong in the town and rural area in which the study was conducted.

The nature of trusting is different for nurses and elderly clients because there are different expectations from the relationships. Both nurses and clients believe that trust is important to the relationship; however, nurses feel that it is essential for clients to trust them. Nurses do not feel that they ever depend on their clients, so they view trust differently. Nurses make every effort to get the clients to trust them so that they are able to provide the nursing care which meets the clients' needs. In home care nursing, nurses are guests in the elderly clients' homes; clients could ask the nurses to leave if trust is not established. Many clients have a basic trust in nurses because of their education. Some nurses believe that many elderly clients have a greater trust of the health care system than other segments of the population because these elderly clients have lived longer and have previously established positive relationships with physicians.

One home care nurse [Penny] expressed her view of trusting in this way: "But they [clients] do greet us ready to trust when you meet them. Somehow, they perceive that this is going to be a helpful person." She continued:

> Yeah, I trust all of them. Why wouldn't I trust them? I mean, they *are* them. I think it is more that I want them to trust me. They let

me into their home as a guest, I'm just a stranger in their home even though I know some of them extremely well. I am still always there only as long as they will want that service or want that nurse.

The Nature of Trusting for Nurses

Nurses consider trust to be an important component of the nurse-patient relationship. Trust is described as "a mutual, kind of a two-way thing, a kind of a two-way process" or a "flow" between the nurse and the client.

> Because you have to trust the client but they in return have to trust you. And that takes a bit of time to develop. [Jenny]
>
> In most of the clients I'm involved with, I would say to a certain degree, to a large extent that there really is a trusting relationship because I don't know that you can have an effective client-nurse relationship without trust involved. You know, to have it a workable one. [Jenny]

All nurses talked about an important factor which affects the nurse-patient relationship in home care nursing. A nurse is a guest in a elderly clients' house; therefore, this relationship is considerably different than a nurse-patient relationship in the hospital. Being a guest in the client's house influences how nurses and clients feel about and interact with each other. Nurses observe the clients in their own environment and clients are more comfortable in their own homes. One of the nurses [Irene] commented on being a guest:

> The other thing about home care that is so different from institutional care is that you have to always remember that you're their guest in their home and it changes how you approach them much more than when you are in an institution. They're there as your guests kind of and you're in control, and you always have to remember that they are in

> control in their own home, and the minute you walk out the door they are going to do what they want anyway because you haven't got your finger on them.

Nurses define their trust of elderly clients in different ways. Trust is considered to be a personal issue, in that nurses have different feelings about how they trust their clients. For example:

> I trust them, but trust them about what? [Penny]

> I probably trust my clients more than [I have probably have trust in] other things in life.... I think people have to be aware of their own sense of trust and what is trust for them. Let's say people distrust people. You are going to have a real tough time doing any service-orientated thing. Right? Because you are always going to be peripheral and remain distant and buffer yourself from any intense relationship. [Jacquie]

Nurses describe their trust the elderly clients in terms of (a) respect, (b) compliance or noncompliance with what was negotiated, and (c) trust to express what they need from the nurse. Nurses also discussed some cases which illustrated that nurses did not trust their clients.

One of the nurses [Irene] felt that she respected her clients but she did not call it trust:

> You have to respect them; I'm not sure it's trust. Do you trust the client?....It isn't trust, it's respect. Because you got to let them choose. You respect their rights and the decisions that they make.... You try and educate them and try to show them why they should maybe do certain things, but you still have to respect that ultimate choice that they make even if they make the one you don't think is right.

Respect was a common theme in the interview. Most nurses talked about the necessity of respecting their clients.

One nurses stated that she trusted her clients to be honest about complying or not with what was negotiated. For her, trust was associated with the clients being open and honest with her. She would trust clients who were not compliant and were willing to discuss this with her. Both the client and the nurse have to be comfortable with the relationship to effectively handle noncompliance. Clients who do not trust their nurses may be reluctant to say they were noncompliant. Nurses also have to feel comfortable accepting client noncompliance and not take it personally. Penny spoke about a client who had not complied:

> I trust that one of them will not be compliant with his pills. I know that about him. We have a relationship that sort of, if he lets me know where he is at, I like to know where he is at because he's over 90, and he is insulin-dependent and it's just nice to know where he is at. And so I trust him, but I trust him to not follow through with what I think he should be doing.

Nurses also trust elderly clients to follow through with the results of the negotiation [Penny]: "If I make your insulin syringes and put them in the fridge, will you be able to remember to take them on Monday and Tuesday and Wednesday? Like I have to trust that you will do that."

Another nurse's view of trust was that the clients were able to express what they needed from her [Jacquie] : "I trust that they are going to be able to express what they need from me. And it is, and I depend on that; I depend on them to be open with me." This nurse was a warm, vocal, vibrant person who focused on empowering clients and used her communication skills to get the clients to open up to her.

Two incidents described by the nurses indicated that sometimes nurses do not trust their clients or their clients' families. One client, who had incontinence problems, was unable to look after herself . Her family insisted that their mother not enter a nursing home. The home care nurse finally removed services because this elderly client could no longer stay home by herself with just home care services and no assistance from the family. Another client had received home care services for some time, but these services were not having any impact on her. This client's health was deteriorating and she was not taking care of herself. Because of the political and legal ramifications in this complex situation, the nurse and her supervisor decided that a written contract was needed. Such are two examples of nurses' lack of trust in their clients.

Nurses have different ideas about what it means to trust their elderly clients. All nurses agreed that it is important for clients to trust them. Nurses could effectively articulate how they got their clients to trust them, but their feelings on trusting their clients were not as clear. In most cases, nurses have a social trust of their clients. Because trust was considered to be a personal issue, nurses had different feelings about trusting their clients. As one nurse said, she trusted them but "trust them about what." The trust between the nurse and the elderly client depended upon the "flow" they had between them.

The nurses also did not have to take the same risks in their relationships with their clients as most clients do, so the nature of trust for nurses is different. As one nurse [Jacquie] said: "I don't have to risk me in my unsafe spots to depend on them." As the nurses are employed by a health care agency, they really do not have much to risk in their relationships with

their clients. The nature of trust between the client and the nurse is different because of the amount of risk that each takes is not equal.

During the validation interviews, some of the nurses defined which category of trusting applied to them. They said that they trust their clients, but realize that other nurses do not. Some nurses felt clients do not have to comply because then they are complying with the nurses' wishes rather than their own. There was also a comment that clients are not always able to express their needs to the nurse because they do not know what their needs are.

The Nature of Trusting for Clients

Many clients appear to initially trust home care nurses. A few depend on their nurses or do not trust them. One elder elaborated: "They [nurses] have a position of trust as far as the senior citizens are concerned." Nurses agreed.

> I think nursing has a stereotyping, and I think that for the most part - very positive. It is that you are a caring person, that you are a nurturing person, that you will take care, that you will have concern, and that you have skills, and I think that society sees nursing as having credibility. [Jacquie]

> Yes, of course, trusting is important, and I think that particularly with the elderly clients, they come to us biased, ready to trust. That part of the job is already done. They come from paternalistic medical interventions; they come from a doctor relationship in years gone by when they say 'You take this medicine, you'll feel better,' you know, and they never asked why or what, [they] didn't have to participate in learning very much or [in] taking responsibility for very much

> because the doctor did it all for them. And that is the health care system they are used to, the elderly ones. And so they have trusted forever and they are prepared to trust just in a general sense because that close relationship with the old G.P. who used to do house visits and who delivered their babies and all that is gone. I think that influences them to transfer the trust to nursing in the community, to a home care nurse, because she is somehow partially taken from that mould, whether it be the country G.P. or the old time G.P. So I think they meet us more than half way in wanting to trust. [Penny]

Another factor which influences the clients' feelings about home care nurses is that they enjoy staying at home. A nurse who can help them stay at home is highly valued. As one client [Mr. J.] reiterated, "To me, well, I had nothing against the hospital, but why should I lay there when I was better off at home? I have nothing against the hospital; I was well treated and well looked after, but you always feel better at home."

Clients who trusted their nurses valued the nurses' suggestions and felt their discussions with them were confidential.

> It seems that [nurse's name] is very important, not a member of the family, but as far as still making a decision you value her opinions and you think about them. [Mrs. W.]

> ...It [trust] means that you can relate to her. And you know that it won't go any further, like you can talk about anything. If you have any problems. [Mrs. J.]

The clients would talk about their experiences and feelings, but they did not provide an analysis as did the nurses.

The clients also spoke highly of their nurses. Five of them had their initial nurse continue to visit them. When they talked about trusting they also related their experiences with hospital nurses or doctors because their experiences with home care nurses were limited. One example was a client who had had both positive and negative experiences with physicians. When asked if trust was important, Mr. J. said, "I do think so. If I go to see a doctor for something, if I really think that he's helping me, I'll do what he tells me to do. " He was also transferring his opinions to the home care nurse. He thought if the nurse was helping him he would do as the nurse said.

As the elderly clients' trust of the nurse could also grow in depth and strength, they became more open and honest with their feelings. These relationships grew with time.

> Well, at first, I liked her [nurse] instantly. But it was more a patient-nurse relationship. More formal. But as time has gone on, it's still there, the patient and nurse, but it's a friendlier relationship. I think it's one that you will always think of fondly, even when you won't need her. Which to me will be sad. But I think she will always be a person you think of very fondly. [Mrs. W.]

Whether the trust developed further depended on the nurse's personality and her nursing skills. As one couple said, "She has a very nice way to get you to know her and I don't know, she makes me feel like you've known her all the time and she's very [sic], she is nice." [Mrs. J.]

> "I think she knows her stuff; she's been at it for a long while. And she's good. All I can say, she's 100%." [Mr. J.]

The clients' feelings of trust towards the home care nurse depends on their assessment of her personality and nursing skills. Several clients commented that they did not want nurses to be pushy. For them, this personality trait was

not conducive to developing trusting relationships: "When anybody starts pushing me too much. I back off, right away. I start backing off. I don't know, I think I've been like that all my life." [Mrs. B.]

There are clients who do not initially trust their nurses. One client [Mrs. B.] admitted she had her guard up.

> There was one nurse -- it took quite awhile, I figured she was giving me the gears, bawling me out [sic] . That was just the impression I got about her at first. And then gradually I got to like her, really when I got to know her.

This client had personal and health problems which may have affected her relationships. A nurse [Sandi] described a nontrusting client: "He's another one who takes a long time to build trust. Once the nurse builds the trust with him, then he will allow her to come late." If the new nurse came late he would not answer the door, or he would call the Minister of Health.

Three of the clients spoke about not trusting some of their nurses in the hospital. One client realized that an aide was not using a sterile technique while caring for his catheter. He told his doctor that he did not want to see this aide again and his wishes were granted. Another talked about nurses in the hospital not giving her the pain medications promptly. The issue was resolved when the doctor wrote down specific times for her medications. One described her experience with nurses who would not answer her bell, thus leaving her in the chair for most of the day. All three of these clients were expressing feelings of anger about their experiences.

There are clients who do not trust their nurses, but are dependent on them so they continue with home care. There are also clients who terminate the services because they do not trust nurses and do not depend upon them. One of the clients who did not trust her nurse was initially dependent on

home care because she was not physically well and had few resources. She tried to cooperate with the nurse and talked about the relationship not working initially because she had her "guard up."

Sometimes clients are quite vulnerable when they are admitted into the program and their feelings affect the relationship. They have more at risk because of their health, and they are more willing to trust. For example, one client [Mrs. W.] stated:

> I was in a real, well, I was really upset by that time. Everything had just come to a point where it got to me and I didn't know who to get or who to talk to, so I got on the phone and I was phoning numbers and I phoned into town a few times and they'd say `Well you live out of town so you have to get a hold of [name].' And I got a hold of a, can't think of her name; well, she was one of the gals that came out to see me and I told her my plight over the phone and I said I was just getting bogged down.

This client was really upset and she appeared to be willing to trust anyone who would help her out.

Nurses supported their clients' situations. They identified some of their clients as being vulnerable and apprehensive in addition to losing control and independence.

> They are in a destitute situation, they are vulnerable to the resources that are out there. [Sandi]
>
> A lot of patients feel they are losing control and every person that walks in there is another threat. Is it to prove that I am not competent? And a lot of them will talk a blue streak and do a good job of convincing you that they are quite okay, whether they are or not....They

are so threatened by new people and each new person is a threat to losing more independence. And they will say so. [Sandi]

The amount of risk the client faces is related to the client's trust of the nurse. For example, there are clients who need only Alberta Aids to Daily Living (AADL) equipment to assist them with their daily activities. These clients do not have to depend on the nurse to a great degree. Elderly palliative clients, however, had many psychological and physical needs which require care. And palliative clients had more to risk if they did not perceive the nurse to be helpful. Hence, nurses tended to get more involved with palliative clients and to establish stronger trusting relationships with them.

Trusting, Caring Relationships

Nurses and clients believe that trust is important to the nurse-patient relationship. Nurses elaborated on how they facilitated the development of trusting relationships. Clients discussed the changes they felt in their relationships, their own level of comfort, and the qualities they appreciated in a nurse. The overall theme in the data is labeled 'trusting, caring relationships.' In this process, home care nurses and elderly clients develop trusting relationships. In addition, nurses provide care to their clients helping them live independently in their homes and clients reciprocate in their own personal ways. Caring is included in the overall theme because the provision of nursing care is part of the process. In addition, one of the conceptualizations of caring is caring as an intervention (Morse, Bottorff, Neander & Solberg, 1991). 'Trusting, caring relationships' encompasses the trust which is developed as well as the nursing care which is provided. The phases identified in this process include initial trusting, connecting,

negotiating and helping. There is a flow between the phases, as some occur simultaneously. Nurses can negotiate and help at the same time. Clients identified connecting as getting to know the nurses and negotiating as working together. Helping is a term which was commonly used by both. These phases encompass categories which describe and enhance them. Figure IV-1 shows the four phases as well as the themes which support the phases. Not all themes were fully substantiated by the narrative data from the informants. As well, termination as a potential final phase of the process was not included due to insufficient data.

After the nurses and elderly clients proceeded through the initial trusting, connecting, negotiating, and helping phases, trust can intensify in strength and depth and the trusting relationships can spiral upwards. Figure IV-2 illustrates a trusting relationship between a nurse and a client which grew and intensified over time. The spiral increases in size indicating that the trusting relationship has intensified in strength and depth. However, if clients are not satisfied with nurses, the trust which was there initially can deteriorate and the relationship can spiral downwards. Figure IV-3 shows that initial trust can be destroyed resulting in a lack of trust between the nurse and client. The spiral decreases in size illustrating the loss of trust. Home care services are terminated when clients are able to manage on their own and occasionally, when nurses feel the services are not assisting their clients. These relationships are terminated when the cycle has been completed once or several times. The client has an influence on the amount of time spent on each phase of the relationship.

Figure IV-1. Trusting, caring relationships.

Initial Trusting
Generalized Trust
Accepting
Respecting
Trust of One's Skills

Connecting
Getting to Know
Communicating
Assessing

Negotiating
Control
Setting Goals

Helping
Being an Advocate
Providing Support
Providing Treatment
Educating
Providing Equipment
Personal Growth

Figure IV-2. Upward spiral.

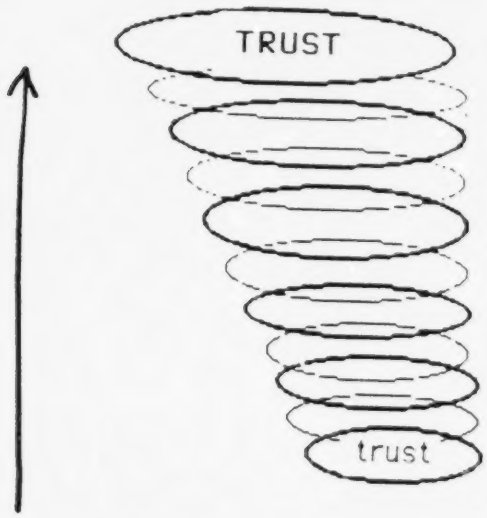
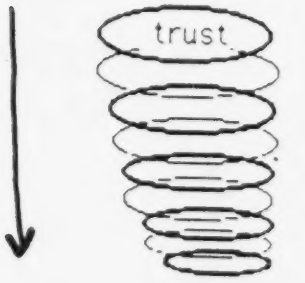


Figure IV-3. Downward spiral.



One of the reasons cited by nurses for developing trusting relationships with elderly clients is to enable clients to live independently. As one nurse [Sandi] explained:

> The mandate and goal of home care is towards independence and identifying other resources that may be there. Teaching them in what ways they can save energy....My goal right from the beginning is "How much can we do towards them becoming totally independent?"

Nurses also focus on health promotion in home care by teaching and empowering the clients which in turn leads to independence. Lifestyle changes are more difficult when the clients are elderly.

> I believe we do health promotion all the time and I think that one of the biggest roles is health promotion. [Jacquie]

For nurses to facilitate client independence as well as a healthy lifestyle, a trusting relationship between the client and nurse is essential. One nurse recognized that nurses have to establish relationships with clients. A client cannot become independent if the nurse is a "doer:" "I think the ground rule is to establish a relationship. Rather than coming in as the doer." [Sandi].

The relationship has been described as being a flow between the nurse and the elderly client. The responses of one affects the other. Nurses appeared to make a real effort to facilitate the development of these relationships. As on nurse [Penny] stated:

> I think it is more that I want them to trust me. They let me into their home as a guest. I'm just a stranger in their home even though I know some of them extremely well. I am still always there only as long as they will want that service or want that nurse.

Nurses also identified differences between elderly clients and the others. When nurses visit, elderly clients feel that their independence is

threatened. They also tend to be less educated, and not aware of the available services. There is a tendency for nurses to socialize with these clients and become aware of their struggles and hardships. Elderly clients are usually quite appreciative of the nursing care which is provided to them.

Initial Trusting

The first phase of 'trusting, caring relationships' is initial trusting. The development of trust was categorized in the following categories: generalized trust, accepting, respecting, and trust of oneself. These categories described the beginning of trust development and if these properties are missing, strong trusting relationship will not develop or may be delayed.

Generalized Trust

Nurses identified that elderly clients exhibit an initial generalized trust of the nurse. Conversely, most nurses also feel a social trust toward their clients. This trust is part of the first phase of the process.

> I think [that] there is probably a bit of trust to start with because they know that you are a nurse and so they figure that you can't be too bad. They are usually quite receptive as soon as you identify yourself, so I think that the initial trust is there to start with. But it would depend a lot on how they interact with you on your initial visit: Whether or not the trust would stay there, or whether it is something that you are going to have to work on as the visits continue. [Wendy]

Clients described the qualities they appreciated in nurses. They talked about nurses being pleasant, friendly, caring, knowing their stuff, and not being pushy. Some clients also had concerns about young nurses. The

clients did not express this, but several of the nurses did. Some clients may feel that young nurses do not have adequate skills and experience.

Accepting

All the nurses spoke of the necessity to accept elderly clients and their wishes. Nurses accepted the clients' homes, cultures, lifestyles, decisions, refusals of services and offers of coffee. If a nurse could not accept the clients and their values, the development of a trusting nurse-patient relationship was impeded. As one nurse [Jenny] stated:

> My feeling is that I am a guest in their homes. If I can't accept what they have got in their homes, their living conditions, then that is my problem, not their problem. And so I have to learn to deal with that problem, either accepting it or saying [that] I just can't go into these situations and then ask for someone else to relieve me.

Sometimes it is difficult for nurses to accept clients' lifestyles. Clients who are "clear in the mind" and "not confused" have a right to stay in their homes even if the nurses think the homes are a "mess." One nurse [Irene] said:

> You see them in their home setting, you see them in their family, you see them in a different setting completely, so that you come to realize that you can't change all those things. You realize that's why they do the things that they do.

Some nurses want to fix the situation according to their standards and have a difficult time accepting.

> It is important to accept the limitations of what the client will accept and feels is their lifestyle and to leave them to live their lifestyle according to their wish and will. [Irene]

Nurses have to accept their client's culture as well as their reactions to it. As the nurses begin to understand the other culture they can start to accept it.

> It was meeting them where they were at and coming to terms very quickly [with the fact] that my value system was quite different and that their culture was different. I knew their culture was different than mine . [Jenny]
>
> I have had an opportunity to go into several homes where certainly their style of living would not be what I would consider to be my style of living or would not even be considered an acceptable style of living, but you have to really kind of forget your own feelings as long as they are happy with it and if they are comfortable with it; then I think you just have to say; 'okay, fine, this is where we start.' [Jenny]

Nurses have to recognize how their feelings affect relationships.

Nurses have to accept their clients' decisions about their health, even if means refusal of services. Nurses provide the alternatives, but clients make the decisions.

> You have to accept their decision whether or not you agree with it. [Irene]
>
> I've had people that said 'No, I don't need service at this time,' and I mean not in an animosity kind of a thing [sic] because it's not usually like that. If they say no, I don't really need service at this time, I'll say fine, but you know we're here if you do. [Penny]

Refusal of services is accepted and the client is encouraged to call the nurse if need arises.

Clients often offer nurses coffee or tea. They may become offended if this offer is not accepted, so the relationship is affected. Accepting coffee when the client's place is "not so clean" places nurses in predicaments.

> You have given them something. They want to be able to give you something back so that you have to accept what they want to give back. And trusting that you can accept them, as well. [Jenny]

The interviews contained only one example of nurses who would not accept a client, a bachelor who was incontinent: "Some of them [nurses] just said I'm not bathing that dirty old man and that was it. And they didn't, they just didn't want to touch him because he was smelly ." [Irene]

Clients also accept their nurses, but they did not talk about it specifically. Their reluctance to see a new nurse illustrates their acceptance of their current nurse.

Respecting

Most nurses spoke about respecting the client's culture, values, feelings, and belongings. Clients also wanted respect:

> She knows my ways. I like my privacy. I don't like people barging in, not even the staff. I paid for this. This is my home. They should respect it. Before they used to leave the door unlocked and everything. [Mrs. B.]

> Well, you want them to respect you as a human being. Just because you are old, you are not actually over the hill. Some of us are more or less in some respects, but then mentally a lot of these people are quite alert, you know? [Mrs. E.]

Respect was identified as an important element in the development of trust. Nurses described their respect of their elderly clients.

> I have a real respect for seniors, I believe that they're a real wealth and so I think because I respect them and I really hold them in a position where they really have the power that they feel, I really feel, [that] I am a genuine person and that comes across and the trusting relationship develops because of that. I'm here to help you, not to change you. How can I help you? [Jacquie]

Nurses respect elderly clients because of their accomplishments, their view of the world, their frankness, their struggles, their appreciativeness and their stories.

Nurses respect clients' decisions, feelings,belongings, and families. However, they do not always agree with clients' decisions.

> Respect for the their [clients'] feelings and their belongings and in a lot of ways, for their families although there is [sic] a lot of times that you would like to take their families and shake them. [Wendy]

> I respect that they [clients] have the choice and that they can make the decision, that they are adult enough and intelligent enough, and know themselves enough that that's okay, whatever they do is okay. Kind of unconditional. [Jenny]

One nurse talked about respecting clients' pets when she has minor allergies to animals. Another one spoke about accepting clients' families when they are not being supportive.

There is a mutual respect between nurses and clients in the clients' homes.

> But I guess there is a different respect for them, there's a different mutual respect between nurses and patients when they're in their own

homes. I guess it's what I said in the beginning -- that you're on their territory. [Irene]

Clients also respect their nurses, as is illustrated by comments such as "She's 100%" and " She has a nice personality." This was also validated by one of the clients when the researcher was presenting the emerging theory to her.

Trust of Their Skills [Nurses and Clients]

Nurses have to be confident and trust their own skills. Clients also indicated that they trust their own skills such as dressing changes and decision making. Their confidence improved after having contact with the nurse.

In home care, nurses have to be independent, and make decisions by themselves because while in their clients' home they do not have anyone with whom to confer. They have to assess how sick the client is, then make a decision regarding appropriate care. Should an ambulance be called? Home care nurses provide a variety of services, and sometimes nurses do not have all of the technical skills required. But having common sense helps. "If you're an uptight person and you're not sure of yourself in the first place, they are not going to trust you." [Irene]

> You're out there by yourself and you come to somebody's house and there isn't any co-worker to confer with somewhere. Even if you call back to the office, there may be somebody there to talk to, but there may not be, and you really have to make decisions on your own and then again some people don't do very well. They feel very insecure in making those decisions by themselves. ....They need the support of older, other nurses or whatever. [Irene]

In home care, nurses have to trust their own skills and decisions.

Nurses have to have a high level of wellness themselves and be in touch with their feelings. They spoke about the personal growth they experienced while doing home care. Sometimes work exposed them to issues they had not consciously deliberated, such as spirituality. Dealing with death is a common situation with which they have to cope, and their feelings affect the care that they provide.

> In the helping professions, people only get as well as the level of wellness of the caregiver . [Jacquie]
>
> If a nurse is to deal with a client or a family who's working through a, let's say a palliative client, you need to know where you are with death and your own comfort level with death to be able to take that family along. And you can only take them to the level where you're at. Occasionally, it can happen where they are beyond, like they really are in touch with their spirituality and are very healthy in their sense, and many times that happens to be where you grow a lot professionally, too. [Jacquie]

Clients talked about their skills to care for themselves. One spouse changed her husband's dressing after watching the nurse do the procedure several times. Another was able to become confident in her decision-making skills. Clients' trust in their own skills are affected by their needs and experience.

Connecting

There is a connection between clients and nurses. Connection is described as "rapport," "understanding," and "comfort level." Some nurses "seem to just have a natural way of clicking with people, like you can feel it." Nurses and elderly clients can connect on a social, psychological, spiritual,

or physical level. Getting to know each other, communication and assessment are integral properties of connecting. Nurses and clients connect in different ways, depending on nurses and clients' interests and backgrounds.

Getting to Know

Clients described connecting as getting to know the nurse. Over a period of time, the relationship "gets friendlier." Clients think "fondly" of their nurses and are "always glad to see them."

> You get to know the person, you can relax and talk to them better and don't feel like you're asking silly questions. [Mrs. W]
>
> You get to know a person and how she works. We talk. I think the relationship is better. [Mrs. J.]

Nurses described establishing a connection with their clients.

> When you get in, it's kind of like a harmony that exists between the two of you. You've got that trust built, the interactions going back and forth. It's a comfort level and they're asking for something. There's a giving and a taking and I believe that on both sides. I don't believe that I only go in and give. I come out sometimes, I think 'wow.' I mean, yeah, if something was to physically see what happens, that person got the dressing changed and you know we talked about this, but I really got something very powerful from that. It was a real gift that was given to me and it's a real, it's kind of like a handlock swinging back and forth. It flows, it's just a rhythm. [Jacquie]

Nurses talked about giving clients personal attention, calling them by name and having eye contact ... showing the clients that they are not a number, but a person with needs that are different than others. One nurse spoke about having a "wide surface" to which clients could connect. Some clients stand

back, needing a distance like a "timid animal," while others ask questions because they want to get to know the nurse.

> They want to know, just to feel that they know you just a little bit better....Because a relationship can't really be a relationship if I know everything about you but you know nothing about me. So that is certainly part of the relationship. [Wendy]

Attachments occur between nurses and clients. Clients "get used to the way" their nurse deals with them and become "quite possessive of their nurse."

Nurses and clients connect on a social level. By talking to the nurses, clients need to get to know the nurse as a person. It takes time to establish a relationship, so communicating about the weather, the garden, the crops, the community or the family helps to bring the two together. If the client knows the nurse's family, it helps to establish the relationship. The nurses know the clients, but the clients do not know their nurse. Clients may need social interaction so that they feel more comfortable with the nurse and see the nurse as being interested in them.

> They're [the clients] not going to tell a lot of things if they don't trust you, and you're right back where you started. So how do they learn to trust you? It's by talking, and sometimes you don't talk about anything medical for quite awhile. [Irene]

> A lot of people will feel more comfortable if you will sit down and visit with them initially. And they might feel more comfortable serving you food or coffee or tea or whatever, to just sort of get the tone set. If you come in there and say 'No, I don't have time to do that -- we have to do this right away,' of course they are going to back off and they are going to get a little bit uptight because they are going to think, 'Oh, she is

not very friendly, and so they start to wonder what is going to happen. [Jenny]

Establishing relationships with clients in the community is easier because nurses see clients in their own environment. Hence, they get to know their clients better.

I would say that it is easier to get connected with a client in the community than it is in the hospital or in an institution of any sort, because they are so much more visible in their lives upon which you can comment or say, 'I have one of those at home' or 'Are these your grandchildren's photographs,' or 'What is your dog's name?' There are so many more ways to build a rapport when you see all the priceless treasures and their husband and their whatever, and their farm's view from the window, whatever the thing is that you can comment upon to show that you are cognizant to their culture and their values and the hard work they have put in and so on. I think it is much easier to go to a client in the community. When they are all wearing little white gowns and in matching beds, in a row, it's harder when you do not know anything about them. [Penny]

Nurses connect on a social level with clients who were initially distanced and reserved. One nurse had crafts in common with her client and it was a "real starting base" for the relationship.

She was doing some crafts and I saw them there and I expressed some interest in them. I've done lots of crafts and that to me was like it was a synapse or a jump and it was like 'oh.' Like, 'you are interested in me' ....A real bond came there and it continued throughout the relationship. 'Cause lots of times there were many reconnections about crafts.' [Jacquie]

This relationship turned out to be quite strong and the client really needed the nurse as time progressed.

To be sociable, clients offer nurses coffee or tea. If the nurses do not accept it, their clients may be offended.

> I knew it was a matter of honor and that became very clear with a lot of clients that when they offered you something, you knew when you could refuse and you knew when you had to sit down and it didn't matter what happened to your day. That was the day you had coffee with them. And if you didn't, you lost them because they were offering. That was the one thing they could do for you, was to offer you something, and you had to accept kind of what they offered you. And if you didn't, you lost them. [Jenny]

One nurse gave her clients small gifts at Christmas and Easter times because some of them were "quite alone." Both clients and the nurse appeared to be happy with this gift exchange: "More often than not they would give me something because they felt they had to and they wanted to and I wanted to give them something back and I would make them a little something." [Jenny]

Connection also occurs after clients are transferred from one nurse to another. One nurse would comment on the commonalties between herself and the client. For example, one client painted and had the same instructor as the nurse: "I think to build trust I, subconsciously anyway, pick up on all the things that I can identify as being quite in common between the two of us." [Penny]

Nurses connect on a psychological level by portraying to their clients that they know how they feel. The nurse shows interest in the clients, which

makes them happier. By connecting on this level, clients do not feel as "alone" or as "hopeless."

> I have a good sense of what loss is so I think when somebody has that it's like, it makes the empathy easier because I have a sense of it, and so I'd often have people say 'you really know what that is.' I really know that you're right there with me and I think that that's a real important part of nursing, is that people sense that you're there in their space and that you understand even for the moment and we're not isolated....To feel that somebody, somebody out there knows something of what I'm saying is a real reassuring thing. [Jacquie]

Connection occurs on a spiritual level. One nurse spoke of a very religious family whose commitment to God assisted them. This nurse was able to understand how much spirituality meant to these people and supported them.

> . . .The power of faith and the things that happen with a very developed spiritual people, who have conviction to the cause and commitment and I think a religious or spiritual maturation gives to that. And it was really powerful to just watch the security that they had in that and they knew that they were so committed. [Jacquie]
>
> If your own spirituality isn't evolved and you are faced with a client who is very spiritual, that's probably the strongest point that they have going for them. It would be definite to me that that would be quite apparent and both sides would sense it. [Jacquie]

Nurses and clients also connect on a physical level. A client expressed her feelings of "feeling good" and "not being so alone" when a nurse hugged her.

> She startled me at first. She took me and gave me a great big hug; it was good but it just about unnerved me because I didn't expect anyone to hug me. It just felt so good and secure. . . .And now we hug one another every time she goes out the door, but that was a big shock to get a hug. Because I really needed it. I felt no one was listening, or nobody was caring. [Mrs. W.]

Providing physical nursing care facilitates the development of relationship with clients. Nurses get " closer" to clients when they provide hands on nursing care. Touching is "very instrumental" in strengthening relationships. Bathing a client can be a "warm, caring time."

> More hands on with home care, and I guess maybe that has some factors to the closeness that you get with somebody too. [Carol]

> . . . When you are bathing an elderly person, helping them in the bathtub, there is a chance for a lot of communication which is kind of a soothing time. You are washing their back, washing their hair; you are drying between their toes, you are massaging their legs when you dry them to improve their circulation, that sort of thing. And they talk and I personally believe that it facilitates a lot of communication. . . . And it is a very close time. [Penny]

Communicating

Communication skills are important in establishing trusting relationships with nurses' elderly clients. Making a good impression during the initial contact is essential because it will influence whether they let the nurse return: "You know if they don't let you in the door, well that's it." [Irene] Nurses talked about being relaxed, listening, being open and honest, as well

as making a good first impression. Nurses must communicate to their clients that they are trustworthy.

Clients described their nurses' personality and skills. Nurses were pleasant, cheery, well groomed, easy to talk to, and positive. Clients enjoy nurses' humor and the laughs they share together. Clients want to feel good about themselves, so nurses who come in and "lift them up" make clients feel happy. Nurses listen to their clients which shows their interest in them. Clients believe that physicians are too busy, so they feel comfortable talking to nurses in their homes. Clients can tell if nurses are caring by the signals they communicate.

> Yes, always well groomed and pleasant. You know, some days you are down tidied up and looking nice, and then you think 'I should do that.' [Mrs. W.]

> And you can tell that she cares. You know, 'I'll be here tomorrow at a certain time to see you.' [Mr. J.]

The relationship between nurses and clients has to be open and honest. Nurses have to be open to the giving and receiving which occurs in a relationship, rather than control it. Clients also indicated that they are open and honest. Nurses see clients becoming more open and honest as both the relationship and time progress.

> I try to be in an open and honest relationship and keep the communication to that. [Jacquie]
>
> And I think you have to be open and to be able to say, there's something here that I've never looked at before and I'm not in total control of what happens in this relationship. [Jacquie]

Calling clients before visiting them is one form of communication. This way, clients expect nurses at a certain time and they know why they are coming.

> What I usually do is, I usually phone the people ahead of time and make the appointment and keep that appointment. Keep as close to that time, and give them some expectation that I'll be there probably in about an hour, an hour and a half, what would be the best time of the day. [Sandi]

Arriving on time is important for some clients, as they may not cooperate if the nurse is not punctual. One gentleman would phone the health minister if the nurse was late. Five minutes was a "very long time" for him.

There were clients to whom a phone call was "kind of an enemy," because they were not comfortable with the telephone. These clients were not fluent in English and they may have also been "hard of hearing."

First impressions are important to home care clients. They can tell if the nurses' mannerisms are very "business like" or "relaxed." Talking about issues which are not "as sensitive" helps the client relax. Clients can sense if a nurse is in a hurry and may not communicate their needs.

> That's their impression, is that you are a hurried rushed person and it takes a long time to do away with that or to change that. [Jenny]
>
> . . . you don't even have to say you're in a hurry if you appear to be in a hurry -- they'll pick up on it. Well, she's in a rush today I won't bother her with this problem. [Jenny]

Nurses talked about listening to the elderly clients and showing interest in them. Home care nurses have to learn to "slow down," "listen," and not "rush."

> Listen to the patient. [The] patient knows what they feel like; they know what works for them and what doesn't and why won't the doctors and nurses listen to them. [sic] [Irene]

Elderly clients can be suspicious of who is coming again. Some of them are suspicious of "who" is coming and "why are they there." By being friendly, showing interest and listening, a nurse can win a client's confidence. Although paper work needs to be done, busily doing paper work at a client's home does not make a good impression. Nurses find that their preoccupation with paper work impedes the development of a relationship. Neither clients nor nurses feel comfortable when nurses do paper work in the home. Clients ask why nurses write things down.

> I'd found it harder to get a rapport with a patient if you were sticking to that form. [sic] [Irene]

> I was busy doing the papers, then I wasn't looking at them the same, and I mean I wasn't looking at them, physically looking at them, because I was busy with the papers. [Jenny]

One nurse spoke about taking "no books, no paper" when visiting difficult clients.

Nurses' clothing communicates their personalities to their clients. Clients have an image of the nurses, and clothing can tarnish that image. For some clients, nurses have to wear clothing which indicates that they are ready to work.

> And if you are wearing silk, you are not here to work. [Jenny]
>
> If I went out in a silk blouse, I'd have never made it past their front door 'cause who does she think she is? . . . . They were very aware that when I was there I was there to work. [Jenny]

One nurse [Jenny] took an Ukrainian language course so she could communicate with her clients. She did not trust an interpreter.

> I'd taken that specifically because there was one lady that I wasn't sure if she was taking her medications [sic]. . . .I needed to know, and I could never be sure, and the son that was living with her I could not trust his interpreting. [sic] He had his own motives and I could never be sure that what I asked was what he saying because the reaction I would get from her was a lot of hostility and anger. You could see it in her face when he was interpreting and it had nothing to do with what I had said because I wasn't saying something that would cause that.

After a few classes this nurse was able to ask the client about her medications. This nurse could also practice her newly acquired skills on other clients.

Assessing

Assessing is included in the connecting phase because nurses have to assess clients to connect with them so that a trusting relationship can develop. Nurses learn assessment skills through education and experience. It is viewed in a holistic manner; clients can have physical, social, psychological, or spiritual needs. Apart from assessing clients to provide nursing care, nurses assess their relationships with their clients. If nurses make an incorrect assessment the clients' health may be at risk, and the relationship could suffer.

Interviews are "real client driven" whereby the nurses fit the interviews into questions for the Alberta Assessment and Placement Instrument for Long Term Care (AAPI) or other assessments. With their clients, nurses explore what is causing their crises, and identify their priorities. Today's needs may be different from the ones that evolve in three weeks. The nurses are open to

letting their clients express what they need rather than identifying what they think they will need.

> Tell me your story and tell me what it's like for you, and not only just the symptoms, but your coping skills and your support system. Those kinds of things, the real big picture, and then how you're part of the picture and who are the most significant people to you, be it the church or your husband or that kind of thing. [Jacquie]
>
> Well, I think that I'm quite up front once we kind of get through who they are and the small talk kind of thing. My first thing is 'What are your needs? What is happening right now? What kinds of things changed? And how do you see [that] I can help you?' So they clearly identify what they know at that time. 'I need somebody to help me with my housework.' 'Is that something that you see our service providing?' Then they use a rhetorical question, they say, 'Well, I don't know but I know that's something I need. . . .' [Jacquie]

By being aware of their clients' developmental tasks, nurses' assessments can identify many needs. However, clients may feel that "they are just fine" and perceive a greater degree of wellness than observed by their nurses.

Although it is an effective questionnaire, the AAPI can upset clients because it is an "overwhelming, detailed thirty-two page tool." Nurses realize that they have to ask the "right questions" to assess the client; however, they feel uncomfortable using the AAPI in the presence of some clients.

> We had an assessment form about things to ask. That's the other thing -- you didn't really ever feel very comfortable about taking that form in with all these questions and checking them off as you went through them. And, I think that felt threatening to the patient, too, if they'd see this long list of questions and you were methodically going

> through them. If you'd just had those areas in your mind and just sort of brought them up. 'How are you sleeping at night? How are your bowels?' Sort of bring the subjects in so it didn't seem to them that maybe you were doing an assessment, a formal assessment but you were. [Irene]

In some areas, other professionals, such as occupational therapists, would do their own assessments asking the same questions as the nurses. Clients would then reply:

> Are you guys writing all this down somewhere so that somebody can say that I can't do this, manage anymore. Who do you have to tell about this? How far does it go? [Sandi]

There were difficulties in assessing and interviewing clients. Nurses had to "listen well" and sense the clues their clients were "sending out." Were the messages that the nurses were receiving congruent with what the clients were saying? If nurses received double messages, they would "go back" and "validate" all of it. Sometimes clients did not say a "whole bunch," so they were difficult to assess. Language barriers could cause confusion. One nurse did not know why her client was only taking two pills a day instead of four. Once the nurse found out that the client thought four pills a day were too many, she could accept it. Nurses felt a "distance" or "barrier" between themselves and some clients. Sometimes the clients' situations could overwhelm the nurses.

> I think there had been a barrier built up so when I came in, there was this distance and so I was very aware of it and I thought, 'Well give them time.' [Jacquie]
>
> And sometimes that's, you think that's kind of a hopelessness where you look at the whole thing and think, 'Oh, my gosh, I'll never

> get through that and sometimes mine is to look at the manageable steps. Then again, knowing where your role is -- Is it to nurture or is it to say 'Well, you know, are these the pieces that need to be looked at? What are you prepared to do right now?' [Jacquie]

Sometimes nurses finished their assessments as they were walking out the door or ready in their car. Clients can wait until nurses are leaving before they express their comments. In addition, leaving the home can assist nurses in viewing the whole picture.

> . . . . Sometimes you walk away and it comes to you when you're driving to the next client. 'Well, gee, what really went on,' and you know, you're kind of getting a feeling. [Jacquie]

> Often they will talk about anything else but what's bothering them for the first while, so that's again, you have to go along with that. Maybe about the time you are ready to go out the door they will tell you what was really bothering them. Because maybe by then they decide, 'Well, maybe it's okay to tell them that.' It takes that long for them to decide whether it's okay. [Irene]

Nurses discussed their assessment skills. One nurse believed that her intuition came from a "knowledge base," "integration," and sense of comfort in her work. Sometimes it took her awhile to sort out what she knew from her knowledge base and what her instincts said. Her instincts were feelings to do or say something.

> . . . . there's that feeling, you think, 'Yeah, this is the right time, or nope.' I back off of maybe disclosing something that they've been asking for. Like you feel like they've shut down and they don't say

it or anything but you think, 'No, today it's different tonight. And so they just go with their pace. [Jacquie]

Well, my guts on this one are that this is real wrong, that they, that we're not seeing a piece or there's a real big piece that doesn't fit. [Jacquie]

Clients also assess their situation to see different problems than the nurses. Although clients did not specifically mention assessment, they appeared to be doing it because they could identify their coping strategies and resources. One clients talked about her decision-making skills improving with the nurse's visits.

Negotiating

After the nurse and client proceeded through the connecting phase, they reach the negotiation phase. The clients called it ' working together,' while some nurses used 'contracting.' The negotiation procedure is influenced by the clients' level of dependence on home care services, in that clients who felt dependent were less likely to want control. Nurses talked about the process of negotiating, of clients taking control, of clients losing control and of setting goals with the clients. The goal home care is to facilitate client independence.

Control

Clients wanted to work with the nurses and they strongly emphasized that nurses should not "take over" or "be pushy." The clients wanted to make the decisions. Nurses were to be "patient" and "understanding." If the nurses and clients were "working together," the nurse would help their clients to make the decisions. Nurses would not say, this is a "better way." Some clients wanted to talk over their decisions with family or friends. Some

thought "smoking" and "having a few drinks" were their own business. Although clients felt that there may be a few times like a family crisis in which the nurse could take over, they mostly wanted to make their own decisions regarding their health.

> But I would never feel that she was trying to take over because she would be talking to you, I'm sure, and asking you for your response as she was doing it. Asking if it was okay. [Mrs. W.]

> I mean to say that you can get more out of people by trying to influence them better than pushing, because people resent being pushed around. [Mrs. E.]

Nurses negotiate with clients who have the cognitive abilities to make choices. Clients express their "boundaries," "needs," and "expectations." Nurses identify what their role is and what resources they can offer. They try to be "flexible" and "positive," following the client's pace. They move slowly, "planting seeds" and allowing clients to think it over and discuss it with their family. Nurses have learned to "let go" and not be as "uptight." They cannot sit with their clients every minute to "make sure" they take their pills. Although there are many resources, there are also program restrictions, so sometimes clients cannot receive what they request.

> . . . . The minute they [clients] think that you are trying to push something on them, something that they are not ready for, that they don't want, they will back off right now and that certainly will affect how your relationship will develop. Because people are used to doing things their way and if you go in there and say, 'Well, your way is not good enough,' then right now, there goes the trust. [Jenny]

> I have them address quite early what their need is and what they think my role is. Because I want that to be compatible. If, you know, I can't come every day, three times a week for the rest of my life, or I can't lose weight for you [sic]. 'What I can do is I can help you with this. I can help you with this and I can help you with that.' So there has to be compatibility. It has to be realistic. So that is what I use as, 'What do you see your need as, and what do you think I can do,' and then linking that up into some sense. 'I can be a resource person for you. I can do this for you. I cannot do this.' I mean, physically there's some things I can do. Again, I try to put it, give it back to them as to what they are prepared to do as well. Like, what is their role in it? It's just not me coming in to save the day. [Jacquie]

One nurse said she negotiated with only some of her clients. For her, there were no formal negotiations, but informal ones occurred.

> I don't negotiate goals with all of them because I find lots of times that they can do it themselves or it's an unspoken thing. Like they know that I'm here and that they will be able to do it in a week or two days or whatever on their own, and then they won't need our services and most people are like that. So I find more the extenuating circumstances where you have to set the goals for them. [Carol]

Nurses let the clients take control or set the pace. There were many stories of clients taking control. One client would let new nurses take only her blood sugars and do nothing else. Others refused to go to the hospital even though they were really sick and hardly managing at home. One nurse thought the word "control" was too authoritarian, preferring "setting the pace." When clients set the pace, nurses have to accept the decisions they make.

One nurse reflected on her past and said that she was a controller, but did not feel that she was a controller now.

> Sometimes, you have to accept the limitations that they set upon themselves, and if they set upon themselves and if they choose, the choice is theirs; you support their choice to the best way that we can as long as we give them the alternatives. [Sandi]

> Well, first of all, I think you have to go at their pace rather than at your own pace. I think people tend to feel quite uptight if you go in there and you are trying to push things. I think that you kind of have to assess where they are at and go with developing things, the relationship, when they are ready for it. . . . You have to kind of give them an opportunity to say what they want. I think if you say, 'Well, that's not acceptable to me,' like the doctor says I have to come everyday, that's going to have them back off right now, and they are going to be a little bit more hesitant about sharing things with you and they are going to really not even look forward to your visit. [Wendy]

One nurse [Penny] felt that sometimes nurses had to be pushy to motivate their clients.

> Sometimes, when we are letting the client set the pace, we have had clients that we have had to push. 'That you should be able to do this yourself, Mrs. So and So' and knowing that she could, but she is emotionally not ready to, or maybe she is too dependent. We have had clients that we have had to push to assume, to try and 'I'll be here, you try and I will talk you through it,' and so we have had

to sort of set the pace. I don't know if they would have less trust or not. I couldn't begin to tell you.

Sometimes the spouses took control. Nurses told stories of spouses refusing home care services because they did not want their "loved ones" admitted to long term care. Nurses encouraged spouses to contact them if they needed help. Sometimes a spouse would call if a need arose.

> The husband is afraid that if the wife is placed and it is obvious that she will need to be, he will not be able to be alone. So he refused to sign the AAPI for release of information. It's his choice. So we have to go along with that. The family is very distraught because they feel that they're [the parents] falling apart in their parents' home, which it seems to be. But it's still his choice. He is able to make that decision. [Sandi]

There are clients who do not want to take control. Elderly clients can be quite apprehensive about home care personnel coming into their homes. They do not want to be placed, but feel nurses have power over them because of their hospital experience.

> Ultimately I suppose, they should have complete control but because they are in a destitute situation, they are vulnerable to the resources that are out there. So when all these ideas are flown forth, they may be afraid to refuse them because they do want to cooperate. I don't know that they would be exercising much control. [Sandi]

Clients tell nurses they do not need some of the equipment they have received.

> They didn't identify it as a need at that point, but they were afraid to say no because they probably didn't understand what was involved. [Sandi]

Setting Goals

Clients and nurses set goals. Nurses realize that they could only do what elderly clients "allow them" to. Nurses observe clients' readiness to set goals and accept their conditions. One nurse saw compliance as the clients responding to nurses' goals rather than to their own. Nurses cited examples of how they assisted clients in setting goals. One example was an eighty-year-old diabetic who liked perogies and the nurse included these in the diet.

> If someone has lived eighty years and they're a diabetic and they still eat perogies and they haven't died and their blood sugar's within normal, and even if it isn't within normal, you have to look at what's real, what kind of impact are you going to make. So what I realized quickly was to try and get the perogies within the diet as opposed to taking perogies out of the diet. [Jenny]
>
> I realize that if they were complying, that it was my wishes they were complying with and not their goals. [Jenny]
>
> Another nurse set goals in her head.
>
> And going back to the goals, I think a lot of times the goals I have in my own head, I know I do and it's only when I have to verbalize them and set them with people who are in circumstances where they may become dependent or you just feel that in order to terminate the situation or to make the best progress, then you have to outline them. Most of them I probably just keep in my own head. [Carol]

Written contracts were sometimes necessary for "difficult clients." One nurse spoke of possible political and legal ramifications with one client, so she had a written contract with her. Another nurse [Sandi] also had some

written contracts. "In other words, the patient is responsible for this and we are responsible for this. And whoever broke the contract then the service may be terminated and we did that."

Elderly clients coped with extensive hardships and felt that they could cope. Many found it difficult to ask for help. Therefore, nurses asked the clients, "How can I help you?" and they proceeded to let them know. Clients may have a different perception of the value of help. A nurse may consider some nursing care as being "minor help," while the client could see it as an "immense amount of help."

> 'Cause we see lots of problems that they don't see as problems. It's their perception of where they are at. That is important for the helping, and for the helping to be effective they have to see that they need that help and they have to value that help. [Penny]

Helping

The last phase of the trusting relationship is helping. Nurses and clients talked about helping and their feelings about helping, as well as what they did for their clients and their own personal growth. The phases of negotiating and helping are not distinct as they can occur simultaneously. Nurses helped clients by providing nursing care like treating, supporting, educating, acting as an advocate, and ordering AADL equipment. Nurses also experienced personal growth. Most of the data from the informants focused on the nurses helping the clients.

Elderly clients described how nurses helped them. Nurses supported them, educated them, acted as advocates, and supplied equipment. Clients expressed their feelings about the help they received. Nurses helped clients to help themselves. Clients credit nurses for helping them. Being able to talk

to a nurse on a weekly basis assisted one client because current concerns were discussed. Clients did not see their physicians that often. Nurses helped clients solve problems, understand their diseases, and fill out forms. Elderly clients with an illness needed nurses to help them stay at home.

> Not only did she listen, she helped us to figure out things and fill out forms. Oh, just step by step, plus she helped me to understand what the disease was and that's what I didn't know when she came into the house. I knew it had a name, but I did not know what it was and through the nurse coming in, is what helped me understand and what helped me accept it. [Mrs. W.]
>
> Because she goes out of her way to help you. She understands and she listens. She will give you her opinion and I like that in people and she's not like giving you her opinions so that's what you've got to do. She gives you an opinion so you think about what you're going to do. [Mrs. W.]

Being an Advocate

Nurses acted as advocates for their clients with physicians, community agencies, and families. Clients feel that nurses have "power" or "more pull" with the physicians than they do. Having only a "short" period of time with their physicians affects what clients can ask them. Nurses are becoming client advocates because of the specialization in medicine. Each physician prescribes something different, and no physician looks after the "total person."

> And no one pulls it together. We don't have that central person to pull it together, and I find that nursing in the community has a big job to do there. To advocate between all the disciplines and to sort of centralize

> the care giving because it doesn't seem to be happening even with the general practitioners. [Sandi]

In the community, nurses set up services from agencies of which, clients are not aware. Nurses reassure concerned families when their "mother" is "managing quite well at home." Clients appreciate having nurses as their advocates: "So a lot of the time we make friends with the clients because we supported their measure of independence." [Sandi]

Nurses helped clients by acting as advocates when they were unable to express themselves. It appears to take awhile for some clients to feel comfortable discussing their questions with their physicians.

> 'And she's been a great help with the doctor, as well. Like she will go to him, 'cause at first I would get too upset and perhaps when you're so upset you're not expressing yourself right, so the nurse would also help there. [Mrs. W.]
>
> I think that helped it like that because she explained better than I could. She could explain to him [doctor] better than I could. You don't know what terms to use so sometimes you don't explain yourself too well. And she would know what she was going to go for. And she wouldn't do it without telling me. I mean she knew how to do it better than I could. Then, if I would go in we would talk it over, the doctor and I, and I would be fine. [Mrs. W.]

Providing Support

Nurses support clients' decisions and empower them so that they can live independently in their own homes. In one area where there were no support groups, clients were "linked up" so they could support each other. When one nurse supported her client's decision to die at home, hospital staff thought she was "nuts."

> They know what's happening, so my thing is really to support them. They know that they need to get on with this, but right now they're feeling pretty tense about it, feeling all alone, feeling this is pretty hopeless and they just need somebody to support them through that time because they will get through it. And support is what I need to do as the nurse. That's the most valuable thing I can do. They don't need information. They've had it all as much as they can handle. [Jacquie]
>
> And I know they [hospital staff] thought I was nuts because they told me I was nuts, you know. Like, 'You're nuts to take him home.' But again I think it was their own value system of 'Why would you want him to go home and die?' [Jacquie]

Nurses took every opportunity to educate their elderly clients, whether it was about foot care or medications.

> I think one of the areas that I really go for in patient education is providing the information and working with patients for them to take responsibility for their health, and whether it is medication teaching, medication appliances, and if they understand and then educate themselves that it is their responsibility and provide the alternatives. I don't think a visit is made without an opportunity toward education. Whether it is foot care, whether it is medication appliance, whether it is exercise, whether it's in dietary nutrition on a daily basis. [Jacquie]

Clients appreciate the support nurses give them. By being available to the clients, explaining information and showing them things, nurses help clients who are upset.

> She just became my support person. I really don't think I could have managed without her. . . . I think that's the biggest important thing of it all, is somebody just being there. [Mrs. W.]
>
> We enjoy her coming in and now it isn't as bad. Like at first when she was explaining things to me, what was happening and that, I would get down, more depressed, my health, but as she showed me how it would work, I would be all maybe upset that something had happened. Then she'd explain it through and now I don't find that so upsetting. [Mrs. W.]

Nurses helped clients to make decisions. One client talked about making her own decisions, but discussing them with her family first. "She always let me make the decision but she was helping me. She's been very good. " [Mrs. W.]

> She gives you maybe food for thought. You think it over, what she said and then I also talk it over with my kids. [Mrs. W.]

Providing Treatment

Nurses provided a variety of treatments such as dressing changes, and blood pressure and glucose monitoring. Many nurses visit palliative clients who require extensive physical care. One nurse commented that it may be more difficult to build relationships with clients who need intensive physical care.

> . . . it is harder to build a rapport when there are dramatic changes in physical health that take all your attention. You become more task orientated, really. The task of relieving pain and the task of providing the oxygen and the task of ordering the wheelchair and the bed - all of this daily living type stuff that makes life easier if your health has failed, and when these things occur in rapid session, you are so

> busy trying to anticipate further loss and provide whatever it is so they are not caught short, that maybe there is less time, less ability to build a really good rapport. [Penny]

However, if clients are really satisfied with the care provided, they may develop a stronger trust of the nurse.

Educating

Nurses also educated clients. One client talked about the nurse teaching her about her husband's disease and improving her coping skills.

> She brought me tapes and I looked at those and that really helped, scared me in lots of ways, the tapes. But it did help and one word that kept coming through on the tapes was `Women were feeling guilty' and she explained to me how that works. [Mrs. W.]
>
> It seemed to work right from the start because I was learning and she was telling me what it was so I guess I went through stages with her. I really didn't know at the time but when I look back I have more definite ideas than I had at first. And I don't feel so scattered. And I don't get as upset. [Mrs. W.]

Providing Equipment

Nurses provide the AADL equipment required by their clients. This equipment assists them with their daily living activities and helps them remain at home longer.

> She decided what needed to be done to the house, fix up the bathroom, put in the shower and seat and bars. She had that done. [Mr. J.]
>
> Like if I needed a walker and a chair in the shower. There were

certain things that I could get through Home Care. If I had to pay for them myself, I wouldn't have anything. [Mrs. B.]

Unable to Help

Nurses cannot always help their clients. Receiving home care services did not help elderly clients who were not willing to look after themselves. One nurse talked about a diabetic client whose blood glucose was continually out of control. Sometimes nurses provided pain medication to palliative clients, but the clients were still in considerable pain.

She had enough medication, it would have knocked a horse out. And still it wouldn't control the pain. The helpless feeling of watching her suffer, I guess. Because you read and hear about the palliative care that they don't have to have pain, that there are so many new ways of controlling pain that they don't have to go through all this terrible excoriating pain. And yet she still did. [Irene]

Nurses Experience Personal Growth

Nurses receive reciprocal help from their clients. They experience personal and professional growth from their relationships with their elderly clients. Nurses find that they "learn a lot" from their clients. They get a sense of "peace in their own lives," a sense of "strength of a marriage," and a sense of "caring." One nurse learned to "accept what she had." They feel that their clients want to give something back to them, so they accept the gifts. A nurse's personal and professional growth from work experiences is a gift from the clients. Nurses gain professionally because they care for clients with certain conditions.

If they [clients] don't feel that they can give you something, be it a joke or a laugh or something, that relationship won't progress either; it will get altered somehow or it will stagnate. [Jenny]

> . . . you learn a lot about yourself and that. You certainly learn professionally, I mean I've taken these skills and the next time I have a case, I think like, 'Wow, this person gave me all this insight.' Like I could help in this way, but like this person really let me in kind of an inside track and really allowed me to kind of share space with them. I have never kind of looked at humanity that way or life that way, and they kind of let me in their door for awhile and that was a real privilege to work with them. [Jacquie]

Nurses appreciated the positive feedback they received from their clients. It made them "feel good," and helped them to evaluate the care they give. These are some examples of positive feedback.

> She's stated that she could have never cared for this fellow that long without us coming in and giving the support physically and verbally and nonverbally and equipment and those kinds of things. [Jacquie]

> And that you felt that you did really help people. Their quality is way better than it had been before you came. This was because they said so. [Irene]

Growth of the Trusting Relationship

After the home care nurse and the elderly client have gone through the trusting phases once, the "trust gets stronger and deeper." One client said that the relationship grew stronger because both she and the nurse wanted it to grow. There also seemed to be a fine line between helping clients and letting them become independent. One client commented that she has

become independent again, and wants to stay that way, but appreciates the help the nurse gives her.

> I think the trust grows after they have received something that improves their feelings and well being. Whether it is dry dressings or advice that worked or reassurance that this isn't so hard and 'I will help you learn it' or whatever. But the trust grows after an action has occurred in teaching or a natural technical action has occurred that worked well for them. Maybe they could cope with whatever. [Penny]

An intense feeling of trust can develop in some of their relationships. Because nurses are human, they get involved in relationships, especially in death and bereavement cases. Nurses' identification with some clients intensifies their relationship. Generally, nurses get more involved in relationships with palliative clients than AADL clients because their risks are greater. If nurses perceive some growth from the relationship, the connection is enhanced.

> I would define being involved with a patient as being really, really involved. Being connected is at a distance, I guess. And home care nurses tend to get more involved because you're meeting the family or in the house. You're part of that. [Irene]
>
> You'd go in and identify what their needs are, and get things set up and probably carry on at a distance and they don't need you that much. Or like a short-term case like post-op dressings or something like that. You may be in there for two or three weeks after, and you're done and out of there. You're involved at the time for a certain extent, it's not that emotional because you know they're going to get better. I guess that's maybe what it is. [Irene]

The trusting relationship can grow deeper and stronger as the nurse provides care to the client. A number of factors facilitate or interfere with the development of this relationship. It ends when the nurse terminates the service.

Termination

Some nurses and clients found termination difficult. Ideally, during the initial visit, clients become aware of the help and resources the nurse can offer and termination will occur when certain goals are achieved. Some nurses found terminating "rough."

> It's a gradual process. It starts on the the first day of the visit when you set up a goal, to manage and cope on their own. And there are those who get very attached and are very difficult to discharge from this program because it became an important part of their lives. [Sandi]

> Sometimes it becomes difficult to break the relationship that has been established between the nurse and the patient, but if the patient has been involved in the initial planning, when the goal is reached sometimes I put the onus on them and say, 'In your opinion what is it that I'm doing here?' And sometimes they see for themselves that it is a social visit. And we discuss the visit and the home care service. [Jacquie]

One nurse recognized that clients were ready to terminate because they were managing their own care.

> . . . The connection or the strength or the intensity isn't there. Like you feel them kind of stepping back and you see them going their

> own way or taking their own direction or perhaps they start -- they phone you and they cancel visits or they're not there or excuses start coming up for visits. I mean those are much more acute ones but lots of times it's a sense of you know, like you really see their own problem-solving abilities coming up and they say this came up and I did that and then you think, 'Whoa, like they're disengaging.' [Jacquie]

Clients are also given the option of returning to home care if they need the service.

> So you always leave them an opening that they can always come back and if that needs to be next week, and having the longevity of the service I found that to be really very effective in reducing the revolving door people. [Jacquie]

Sometimes services are terminated because clients refuse home care services and nurses feel that contacting them would not be beneficial.

> I can think of one situation where the husband wouldn't let us bath, and he wou about frustrated out of her mind. We finally had to withdraw from there because we couldn't do anything. [Sandi]

Refusal of Services

A client can also refuse home care services; however, the nurse sometimes continues to have contact with the client. Trust can also develop if a client has refused services. Some elderly clients do not perceive they have a problem or may not be ready to receive the service. Some feel home care is the first step to leaving their homes, and others want to remain independent. Nurses leave their phone numbers so clients can contact them.

A stronger relationship can develop because clients realize that nurses will "back off" if clients so wish.

> But even after the connecting, they will know that we will back off, that we agree with them. They are coping well enough to the best of their ability, and we will leave and here is our phone number and they can call later. There is trust there. Some of them do call later. So just the connecting; yeah, there is some trust generally. Even without actually doing an intervention per Se." [Penny]

Lack of Trust

The relationship between the nurse and elderly client would be different if there was no trust or minimal trust. The client would be reluctant to let the nurse inside the home. If the nurse was allowed in, the client would not permit the nurse to perform certain tasks. Sandi spoke about a client who would only allow a new nurse to do things she could not do herself. This lady was blind and could not take her own blood sugar and this was the only task the relief nurse could do. This lady was dependent on the nurse to monitor her blood sugar and nothing else. This client did not trust new nurses, but had a trusting relationship with her regular nurse.

This relationship between the client and the relief nurse shows that the client had minimal trust in her. There was no initial trusting because the client was only dependent on the nurse to monitor her blood sugar. The connecting and negotiating phases were negative experiences for both of them. The nurse did not get to know the client or do an adequate assessment of her. The client controlled what was to be done and the nurse provided the treatment. The amount of help the client received was limited. When the regular nurse came, the client allowed her to provide more

services. So nurses are providing minimal or no help when a trusting relationship is not established between themselves and elderly clients.

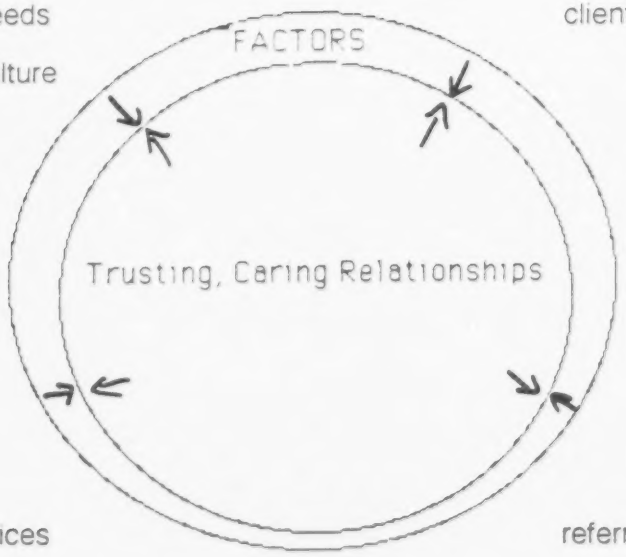
Factors Affecting Trusting Relationships

Nurses and clients identified factors which can facilitate or interfere with the development of trusting relationships. Figure IV-4 illustrates how the factors influence the trusting, caring relationships. There is an interaction between the factors and the process of developing trusting relationships. The factors incluce the length of time in home care; having the same nurse; the identity of the initial nurse; the client's needs; the client's personality; the nurse's personality, skills, experience and priorities; the client's gender; the client's culture; the nurse's relationship with physician; other services; and referral to home care.

Figure IV-4 Factors facilitating or interfering with the development of trusting relationships

length of time in home care
client's needs
client's culture

identity of the initial nurse
client's personality
client's gender



other services
having the same nurse

referral to home care
nurse's relationship with physician

nurse's personality, skills, experience and priorities

Time

Trusting relationships develop over time. The longer the elderly clients receive home care services from their nurse, the stronger the trust becomes. Nurses say that it takes a long time to see changes for some clients. Over time, they relax.

> It takes probably two or three visits before the client starts to relax enough to really open up and start the relationship. At first you're just there as a stranger and as the visits increase, then it becomes an event, a positive event for the client. [Irene]

> I think the longer the relationship, the more involved it is definitely. Definitely. 'Cause I've got some people I've had for two or three years and I'm very attached to those people. Somebody that you've only seen a couple of times or even for a few weeks, you aren't going to have the same relationship with. [Carol]

In today's health care system with the heavy workloads, nurses have less time to spend with their clients. One nurse said her clients complained because she was not spending enough time with them. With her workload, this nurse did not have enough time. So spending adequate time with clients facilitates trusting relationships while insufficient time interferes with the development of trust.

Trust of nurses depends on whether they are seen on a regular basis. Clients and nurses get a chance to connect and know each other. Having the same nurse come regularly facilitates the relationship.

> Once they see that you're going to come regularly maybe they start getting used to it and letting you do a little bit more. [Irene]

> I think that coming regularly is the other thing. If you just sort

of appear once in a while, then they don't really trust you either. I think that's part of it. [Irene]

Having the Same nurse

Elderly clients enjoy continuity. They find it difficult to establish rapport if their nurses keep changing. When the same nurse visits, clients and nurses get to know each other and the relationship gets "stronger." Most of the nurses kept the same elderly clients, and if changes were necessary the initial nurse would explain the reason for the transfer and also introduce the new nurse. However, one nurse talked about a client who had had seven visits by seven different nurses. This client begged for this nurse to come back. When the nurses are transferring clients to new nurses, elderly clients ask if they are "nice " and "skilled."

> When clients are told a another nurse will be coming, their questions almost always asked include, 'Is she nice?' 'Does she know what she is doing?' So it shows a lot of insecurity. [Sandi]
>
> And the other thing is the client is much more apt to ask questions and relate to the nurse that is coming and have a rapport with that client than a new one. And they tell me so, and I put myself personally into that situation and if I had a new nurse or a new person coming in my door every visit, I would be reluctant to follow through unless it was something obvious. Sort of life and death. It does take time to establish a rapport and to continue. This client is sitting there. If the client is threatened by the nurse who walks in, he or she will not hear anything she is saying, anyway." [Sandi]

Having the same nurse facilitates the development of a trusting relationship.

The Initial nurse

The first nurse establishes rapport with the clients and the other nurses have a difficult time meeting clients' expectations. Clients develop a "bond" and a "soft spot" for the first nurse finding it "difficult to change." A relationship with the second nurse is a "bit different." Nurses said that other nurses are never perceived as being as "good." One client did not readily adjust to other nurses. The first nurse establishes "tracks in the snow."

> . . . As kind of likening it to tracks in the snow. That first nurse comes in, paves two tracks in the snow, and then people just expect that you will be that person. [Jacquie]
>
> The nurse who primarily goes in, the first caregiver, even the person who's gone in and done initial assessment, you always follow in the tracks of that first nurse, always and that's a real, that's an always for me. I hate to be so inflexible in my grouping, but we see that all the time. You always hear about that first nurse who came in and it takes a long time for your own identity to be set up with those clients because they deal with, well, `Such and such came and such and such.' You hear them for a very long period of time. [Jacquie]

The Client's Needs

The client's needs influence the development of the relationship. If the needs are assessed to be great by either the client or the nurse, an intense relationship can develop. The client's apprehension about home care has an effect because they may need help but feel that they are losing their independence. Trusting relationships with apprehensive clients take a long time to develop.

> If a client is apprehensive about the visit, the relationship takes longer to get established. [Sandi]

> They are threatened by new faces and competency and they are under stress to begin with. They have probably just come out of the hospital after a bypass and maybe they have an infection on their incision and need dressings, and that a new nurse might not know [Sandi]

Nurses and clients assess clients needs differently. Health professionals may see "lots of needs" while clients may feel that they are "just fine." " They [clients] perceive more wellness than we do in our assessment." [Penny]

Nurses get involved with palliative care clients who require intensive nursing care. Relationships become more intense if the cases are "complex" or nurses are dealing with death and bereavement. Nurses feel more "emotional" and "personal" involvement in these cases.

> The relationship with palliative clients, whether or not they are seniors -- I know your focus is elderly -- but, it is really quite privileged. They share extremely, like dying is the most personal thing you do and to be allowed into that extreme relationship of love and support and grief and so on, both on the person's part and his family's part, to be allowed to share in that, to be a witness to that is a real privilege and just to be a witness to their courage and their coping, that really is an intense experience and I really feel, I really do, I don't mean to sound like I am speaking platitudes, it really is something. [Penny]

> It's emotional. Differentiates between palliative and the rest of the clients. [Irene]

If nurses do not perceive that clients have extensive needs intensive relationships do not usually develop. AADL visits, when nurses provide equipment, may be an "in and out" visit with little involvement between the nurse and the client.

> . . . So it depends on the clients' needs as to how involved we can become with them, and their needs depend on their health status. [Carol]

> . . . You'd go in and identify what their needs are, and get things set up and probably carry on at a distance and they don't need you that much. Or like a short-term case like post-op dressings or something like that. You may be there for two or three weeks after, and you're done and out of there. You're involved at the time to a certain extent; it's not that emotional because you know they're going to get better. [Irene]

Not having other support systems influences clients' perception of their needs. One nurse said an elderly male client felt she was "wonderful" because she monitored his medications and blood pressure, and picked up his mail. This client did not have family or neighbor support so he depended on the nurse. Because of our busy, transient society, elderly clients may not have the support systems of previous decades. Nurses become the clients' major support systems.

> . . . The neighbors have moved away; there may be younger people that moved in. They don't know any of their neighbors. Those clients are really isolated. And with families being busier now with both the husband and wife working, their resources are limited to the

elderly, as well [sic]. The extended family that was there to support is just fewer, much, much fewer in number." [Sandi]

The Client's Personality

The client's personality affects the relationship. One client who had a great relationship with her nurse considered herself to be trusting and wanting the relationship to work. Other clients who are not trusting need considerable time to connect. One nurse said a client yelled at her, and she told the client that she would leave if she kept yelling at her. Clients who are dependent have different relationships with their nurses. So clients' personalities affect the development of trust.

> I had one client who is very, very, very eccentric. It took me almost two months before she trusted me. It seems that to her I'm the only one now whom she can trust and if I'm away or on vacation she is very traumatized because this new nurse doesn't know anything. [Sandi]
>
> A lot of these people seem to have had a dependent personality throughout their lives and it hasn't changed very much. A lot of them are very afraid. They're older and the nights are long and they have much time to think about things that might happen. [Sandi]

Nurse's Personality, Skills, Priorities and Experience

Nurses can facilitate the development of trusting relationships. Some nurses facilitate clients' dependence by doing "everything" for their clients. By fostering client dependence, nurses impede the development of trusting relationships.

> Some are willing to do more for the patient than maybe they should, and so then the patient starts to expect more. And it's hard to get out of that once you've set that up. [Irene]

Home care nurses need to be versatile, make their own decisions, and have nursing skills. They must be confident in their technical, assessment, and decision-making skills because the demands of home care are "broad." Changes in plans mean that nurses have to priorize their work and be adaptable. Some nurses have difficulty with decision making and technical skills.

> This one needs me more, but some nurses can't handle that. [Irene]

> And the nurses without experience have difficulty adjusting. For instance, in the hospital insulin is usually checked by two people and the first time a young nurse comes out she has to do insulin on her own. [Sandi]

Clients recognized skilful nurses, feeling that it is important for nurses to provide safe nursing care. One client commented on a nursing aide in the hospital not using a "sterile technique." Some clients question young nurses possibly because they feel young nurses do not have adequate experience: "Yes, and I think she knows her stuff, she's been at it for a long while. And she's good. All I can say is for her, she's 100%." [Mr. J.]

A nurse spoke about professionalism. Nurses with high standards will influence relationships with clients. ". . . If you don't have those high qualities of standards, how will we go?" [Jacquie]

Nurses have to deal with their own feelings. Death is one area where nurses have to be in touch with their own feelings so they can help their clients cope. If nurses are not comfortable with death, they may not be able

to assist their clients. Palliative care is also stressful. Nurses have to be aware of their stress level so that it does not interfere with the relationship. Today there are heavy workloads.

> . . . You really need to know where you are with death and your own comfort level with death to be able to take that family along. And you can only take them to the level where you're at. [Jacquie]

> It's stressful. Palliative care is very stressful. [Irene]

Some nurses are willing to take some risks to help clients. One nurses said that she was a risk taker, but she was aware of her boundaries and had good relationships with the physicians. She went out of her way to help clients and was willing to try new ideas: "Usually there is a risk but I am a risk taker." [Jacquie]

Clients describe nurses as being nice, pleasant, efficient, and eager to help. They want to "get to know the nurse." They appreciate nurses telling them that they will find out if they do not know something. Kindness and a willingness to help are recognized.

> She has a very nice way to get you to know her and she makes me feel like you've known her all the time and she's very, she is nice. [Mrs. J.]

> . . . when people are kind and they are trying to help and you recognize it and you don't feel that they are pushing you generally, because they are not. No, our nurse isn't the pushy kind at all. She is tactful and she tries. [Mrs. E.]

Client's Gender

A client's gender can either interfere with or facilitate the relationship. One nurse said that her sense of humor helped her to get along with men. Culture affects males' acceptance of home care. Another nurse felt some European men expected their wives to look after them, and were not receptive to services. Sometimes male elderly clients "test" or "embarrass" nurses. Nurses can get upset, calling them "dirty old guys." It is difficult for bachelors who have been independent for all of their lives to have female nurses enter their homes.

> I feel that female patients are more receptive to intervention than the male patients. The male patients take a little longer to build up the trusting relationship. And, especially if the male patient is married, the cultural background, the lady of the house looks after the man of the house. And if the lady is there and although she might not be capable of assisting in his care, he expects if still. And if is very difficult for him to accept outside intervention. [Sandi]

> I guess some elderly men that have always lived alone have a really hard time having this, whether you are young or not, they see you as young nurse coming in and trying to tell them what to do. They've always been independent, they did their own cooking, their own cleaning, whatever, and suddenly now when they're old to allow a female in the house; to even tell them or help them with anything is pretty hard for them. Because it's losing a lot of their identity and in the community they've always been independent. [Irene]

Client's Culture

The client's culture influences relationships. Some of the clients who do not speak English do not understand the nurses. One nurse enrolled in "Ukrainian classes" to facilitate communication with her clients. Some European men feel their wives should care for them, so they do not accept services even if the women need help. One nurse spoke about native clients who finally trusted her after two years. She felt that it would take her three months to establish these relationships in a nonnative community. She stated that natives trust her because they have become open and honest. This year, one client told her he was not taking his insulin. Last year, he would not admitted this.

Physicians

The physician influences relationships between nurses and clients. One client was asked by his doctor if he wanted to go home and have a "qualified nurse" change his dressing. He was happy with these arrangements. If the nurse and physician work as a team, then the client receives better care: "If the doctor said I want you to have the nurse come and check you, they seem to accept that quite well. That made it quite easy if the doctor did that. " [Irene] Nurses find that clients are very loyal to their physicians and nurses dare not question or criticize doctor's orders because this can upset the clients.

Other services

Sometimes other services influence the client's relationship with the nurse. One nurse talked about working on a team of four professionals, and the clients got confused with this number of people coming in to assess them. Other home care services such as homemakers and physiotherapists are

also important to the clients, who may see them as being more important than nursing.

> Your patient doesn't know who is who after awhile. And many of them have a hard time relating to one person and not four. [Sandi]

> For most of the seniors that we see in our program, the most important person is the homemaker because she helps them with their bath, she house cleans, she cooks for them, she may do their shopping and she keeps their house looking the way it always had been. She is the most important person to them. [Penny]

Referral to Home Care

If the client is not aware who made the referral it affects their acceptance of the service. If clients refer themselves, they will look forward to the visit. If someone refers the clients and informs them of the referral, clients are usually receptive. Sometimes friends or neighbors make referrals but do not want the client to know who referred them. This can make the situation difficult for the nurse. Sometimes family members insist that clients should receive services even if they are doing fine.

These factors were identified by nurses and clients as facilitating or interfering with the development of trusting relationships. The factors which were consistently mentioned as influencing relationships were length of time in home care; having the same nurse; the identity of the initial nurse; and the nurse's personality, skills, experience and priorities.

CHAPTER V: DISCUSSION

Nurses and elderly clients identified trust as being an essential element in nurse-client relationships which is supported by both the theoretical and empirical literature. For home care, the main goal was client independence which both the nurses and clients generally supported. To promote client independence, trusting relationships have to develop between the clients and the nurses. This chapter integrates the theoretical and empirical literature with the findings of this study. The research and literature which was presented in Chapter II will be discussed.

Kristjanson and Chalmers (1990), in a recent study called Nurse-Client Interactions in Community-Based Practice: Creating Common Ground, also identified themes similar to the ones in this study . Their goal was to describe nurse-client interactions in public health settings. The interactions were labeled "creating common ground". The eight themes within their conceptual schema were interaction phases, content, assessment approaches, nursing interventions, control, nursing style, care context and rolling evaluation. Their study was different from this one because their interactions were between the public health nurses and clients. Their interactions were videotaped in a variety of settings and afterwards, both the nurses and the clients were interviewed. Their interaction phases included social and working which are similar to connecting and helping. Assessment and nursing interventions were included in "creating common ground". They identified two types of control in the interviews, nurse-control and joint-control. In the nurse-control, the nurses had their own agenda while in joint control there was a balance of interaction between the nurses and clients. The home care nurses in this study described their ideal as being joint-control. Nurses controlled interviews on occasions and if clients had total

control the home care nurses terminated the visits or waited for the clients to get comfortable with them. Their themes of nursing style and care context were described as factors in this study and their last theme of rolling evaluation would have been viewed as assessment. Kristjanson and Chalmers (1990) identified some themes which were similar to the ones in this study.

Morse's study (1990) documented the four types of relationships nurses have with clients: clinical, normal, connected, and overinvolved. In the clinical relationship, the nurse had brief contact with the client. In a normal relationship the nurse had a professional interaction of short duration with a client who had minor or moderate needs. The connected relationship was intensive and close and the client had extensive needs. In the overinvolved relationship, the nurse had an intimate relationship with a client who had enormous needs. By being overinvolved, the nurse was committed to the patient only as a person and the treatment goals were discarded. In this study, clients who need AADL equipment were identified as having clinical relationships with their nurses because the visits were brief. Normal or therapeutic relationships were formed when nurses changed minor dressing because these clients are seen for two or three weeks. In this study, many of the relationships with the elderly clients could be considered as being connected because they were seen for extended periods of time and close relationships developed. Since the nurses tried to facilitate independence, they connected with the elderly clients to assist them. Elderly clients tended to have health conditions which were more chronic in nature. Although the nurses talked about being involved with their clients, they would not be classified as being overinvolved. The home care nurses were committed to the treatment and did not discard treatment goals.

This study had similar themes to those identified in Morse's (1990) study. She stated that patients and nurses negotiated the relationship which included patients assessing the nurses and vice versa. Some of the strategies used by the nurses and patients to increase involvement were identical to the ones in this study. Morse (1990) was concerned about nurses' interchangeability and their reporting system interfering with trust development. The nurses and clients in this study clearly identified that nurses were not easily interchangeable. In addition, the elderly clients were not always aware of the information written in the nurses' charts as many nurses did not take the assessment tools into the homes. If the assessment tool was taken into the home or other professionals asked the same questions, clients questioned why all this information was needed.

The trust clients had for nurses was similar to the "naive trusting" described by Thorne and Robinson (1988). The clients assumed that the nurses would help them. The six clients who were interviewed were satisfied with the nursing care, so disenchantment and guarded alliance were not identified in this study although it might have been if the sample size was larger. Robinson and Thorne (1988) did not document reports from clients who were either dependent or mistrustful of their health care professionals. The health professionals in their study were mainly physicians, a possible reason for differing results. The clients in this study felt that the nurses cared about and understood their feelings and interests. Although the nurses identified a "testing" stage (clients did not say that they tested the nurses), the trusting relationship was not disrupted, therefore, it did not have to be reconstructed. Since there is no disenchantment phase in this study, some of the trusting relationships may be stronger and deeper than the reconstructed trust identified in the other study.

Some of the home care nurses trusted that their clients were able to express what they needed from the nurse. Thorne and Robinson's (1988) description of trust in patient's competence is similar to the trust expressed by some of the home care nurses. In their study this trust meant that patients were able to make, share or delegate decisions in such a way that their own interests were protected. Both nurses and clients in this study identified that negotiation occurred, and the clients made or shared in the decision making. As in the other study, trust from the health professionals played an important role in fostering client competence. Clients were able to relate how their confidence in decision making and other self caring skills grew with their nurses' assistance.

Thorne and Robinson (1988) documented the strategies patients used to get health professionals to trust them such as giving selective information, being noncompliant and demonstrating that they were informed. The elderly clients in this study did not identify such strategies, with the exception of the one client who did not initially like her nurse. This client did try to cooperate with her nurse and the relationship turned out to be satisfactory. One of the home care nurses felt that clients who withheld information of noncompliance were not trusting their nurses. Thorne and Robinson (1988) described that patients who were trusted by their health care professionals were able to return the trust. One of the clients in this study described this experience of developing a strong trusting relationship with her nurse which illustrated reciprocal trust as described in the other study.

Rotenberg's (1990) measure of trust beliefs of elderly individuals was not demonstrated in this study. Using Rotter's trust scale, he found a complex relationship between trust and income. Income correlated positively between two factors, dependability of social-legal organizations and fear of being

cheated, but negatively with the third factor, dependability of specific social groups to fulfill their promises. In this study, two of the clients said they had a low income, however, they appeared to trust social-legal organizations and definitely trusted their nurses. Two clients refused to let the researcher tape their interviews so perhaps they were not totally trusting, however, their income levels were not the same. None of the clients indicated that they were fearful of crime, but crime was not a concern in their communities.

Some of the findings from this study are supported by psychology research. For example, Giffin (1967) stated a person had to have an uncertain objective in a risky situation in order to trust. The different types of risks clients and nurses faced were illustrated in this study. The clients and nurses expressed that reliability was important and this was the focus of Rotter's (1967) work.

There were other studies which this research cannot support nor refute. Deutsch (1961) found that subjects who were trusting were also trustworthy and subjects who were suspicious were untrustworthy. Schill, Tores and Ramanaiah (1980) studied whether interpersonal trust moderated effects of life stress. They found that subjects who scored low in trust had higher stress scores and reported more emotional and physical distress. People who felt powerless were less likely to trust others. Since this study was qualitative and the themes from Deutsch (1961) and Schill et al. (1980) research were not extensively expressed, this research does not supported nor refute their work.

The antecedents and consequences of trust which were expressed by Meize-Grochowski (1984) were identified in this research. The following antecedents of trust: consistent behavior by the nurse and the patient's having a previous positive association with the nurse or nursing were

identified by nurses and clients as factors affecting the relationship. In addition, the consequences of trust as being a sharing of feelings and an openness or honesty between the nurse and the patient was illustrated.

This study confirmed the existing theoretical literature on trust. The following three ideas documented by Ruditis (1979) are supported in this study: the key to a trusting relationship is communication; for this relationship to blossom, time is an essential factor; and the nurse has to be credible, consistent and trustworthy. Meize-Grochowski's (1984) defining attributes of trust; attitude; reliability; confidence; bound to space and time; and fragility were also supported in this study. The clients felt confidence in their nurses and the nurses were reliable. Time was an important factor in trusting relationships.

May (1990) indicated that the theoretical literature described how nurses should interact with their clients, however, the research showed that the social organization and hospital administration did not facilitate theoretically appropriate communication. Many of the interactions between the nurses and the patients were routinized, controlled and superficial. In this study nurses tried to have quality, open communication with their clients. However, sometimes the nurses were stressed because of their workloads and time commitments.

The informants in this study expressed a strong desire to maintain independence which is similar to the findings in Magilvy et al. (1988) study. Their study found that home care was initially helpful, but was perceived as supporting dependency as the patients became well and able to undertake self-care. The data from the clients in this study did not support this finding. A fine line between independence and helping was identified, however, none of the clients thought home care was fostering dependence.

Elderly clients have different developmental tasks as well as a varied amount of experiences which affected their relationships with nurses. The home care nurses respected and accepted their elderly clients because they were survivors succeeding to reach old age and possessing strength and abilities to cope with stressors and changes throughout their lives (Golander, 1987). In Golander's (1987) study, the elders developed coping strategies to stay in an institution while in this study the elderly clients shaped their lives so they could stay at home. The coping strategies for some of the residents included studying their own bodies carefully and serving them patiently, planning one's actions carefully, avoiding unnecessary dependence and strengthening relationships with helpers. The home care clients had different strategies because they had more independence, however, the process was similar because they wanted to stay at home.

For some of the elders, entry into home care was similar to Chenitz's (1983) description of clients' passage into a nursing home. Some of the elders felt that admission into home care was the first step of the passage into a nursing home. This can be a crisis for the elderly clients and they tried to resist it or their family resisted it. Trust has to be established between the nurse and client so the client would have a positive experience in home care or the nursing home.

The results from this study are compatible with the World Health Organization's (1981) strategy of "Primary Health Care - Health for All". In this strategy, individuals have full participation in their health care, in the spirit of self-determination and self-reliance (Mahler, 1981). In the negotiation phase of the relationship the elderly clients participated in their health care as the nurses let the clients set the pace, and take control. Trust in the nurse

and the clients' competence has to be established for primary health care to succeed.

Benner (1984) wrote about the expert nurse as one with an enormous background of experience having an intuitive grasp of each situation and zeroing in on the accurate region of the problem. Some of the nursing informants illustrated their expertise during the interviews. They were able to discuss their experiences as well as the phases of a trusting relationship. Benner (1984) also identified the helping role of the nurse in which the nurse provided comfort and communication, maximized the patient's participation and control, and guided the patient. These are similar to some of the strategies discussed by the home care nurses. The findings of this study relate to Benner's (1984) work on nurse's expertise and the helping role .

The findings from this study are similar to the themes identified by other researchers. The results are also compatible with the World Health Organization's (1981) strategy of "Primary Health Care - Health for All". The theoretical and empirical literature supports the nurses and elderly clients' identification of trust being an essential element in nurse-client relationships.

CHAPTER VI: CONCLUSION AND IMPLICATIONS

Meaning and Implications

Trust is an important component in the nurse-elderly client relationship. Clients have to trust the nurse's competence and personality so they can receive the benefits of home care. Nurses have to trust that clients are competent and able to express their needs. When the goal of home care is to facilitate client independence, a very appropriate goal, trust becomes essential. Clients who have control of their lives become empowered and feel good about themselves. The fine line between independence and dependence should be respected.

The helping that nurses provide is different from that of other professionals like psychologists and therapists. The therapists see clients mostly in their offices so they do not see the clients' environment. Nurses can also provide clients with a broader range of services, such as treatment, education and advocacy. So it is questionable whether all theory which is generated in psychology is generalizable to nursing. The nursing context is different, so the theory may only be partially generalizable.

Forming trusting relationships is especially important when dealing with elderly clients who have complex health problems, few financial resources, lower education levels, or different cultural backgrounds. Clients can be considered to be difficult or noncompliant because nurses do not understand the clients and their reasons for their actions or the factors the clients are faced with daily to survive. Nurses have to trust the clients' competence even though they may not agree with clients' actions.

The findings from this study have implications for nursing practice. Nurses starting in home care can read this study to get a better understanding of the realities of home care. Administrators may use these

findings for staff orientation and development to facilitate client independence and empowerment. Nurses visiting clients from different cultures may find this study useful. Nurses should have the opportunity to apply nursing theory in practice, although according to May (1990) this does not seem to be happening in nurse-client interactions in some nursing areas.

More research needs to be done in this area. Is the development of trusting relationships similar in different nursing areas? communities? cultural groups? The development of valid and reliable tools to measure trusting relationships between nurses and clients is needed.

There are implications for administrators in the area of assignments. It is important that nurses have sufficient time to spend with the clients so they get to know each other and the relationships get established. This may be difficult in times of restraint, however, spending more time with clients initially may be more cost effective, as clients have their needs cared for and feel more confident. These clients may not enter the health care system as frequently. There are implications for the home care client classification system. The system has to accurately reflect the clients' needs. The time factor is essential because it takes longer to teach someone than to do the action. Being aware of the factors which influence nurses-patient relationships is important. For example, the nurses' stress level affects their interactions with clients.

In education, the focus should be on client independence rather than client compliance. These findings can be useful in teaching students. They can learn about initial trusting, connecting, negotiating and helping.

Limitations of Study

One of the limitations of this study was the low number of dyads. This limited the clients experiences with home care nurses. Other nurses who

were interviewed were hesitant to ask their clients. Some said their clients did not meet the criteria or were unable to be interviewed at the time because of health or personal reasons. The clients in this study were very supportive of their nurses which they probably had every reason to be. If there were more nurse-client dyads, the finding may have been different. There were clients who could not be interviewed because they were not articulate.

The nurses in this study had a vast amount of experience. The limitation was that no new home care nurses were interviewed. The nurses who volunteered also appeared to be quite comfortable forming relationships with people. Nurses who felt this topic was important volunteered to participate. The informants were able to describe negative situations, but there were no negative cases.

Nevertheless, since the focus of this study was trust these informants were able to elaborate on their meaning of trust. They were knowledgeable about trusting relationships because they were involved in trusting relationships and were able to describe them. These informants allowed the researcher to focus on trust rather than the lack of trust.

Summary

Trust has been identified as an important component of the nurse-patient relationship (Morse, 1990; Ruditis, 1979; Thomas, 1970), but nursing research on this topic is not extensive. Also, trust in specific areas of nursing practice such as home care and gerontology has not been examined (Rotenberg, 1990). The development of the trusting relationships between home care nurses and elders is an important focus for research. The essential research question for this study was 'What is the nature of forming trusting relationships?' The two other questions that stemmed from the initial question are as follows: (1) what is the process of developing a trusting

relationship between home care nurses and elderly clients; and (2) what factors interfere with or promote the development of this relationship?

The process of collecting and analyzing the data took approximately nine months. Data was obtained from seven home care nurses and six elderly clients who were interviewed from one to three times. Appropriate approval and consents had been received. Two of the nurses asked their clients if they were willing to participate so there were two dyads. The data was analyzed using grounded theory approaches and Microsoft Word Processing on a Macintosh computer.

Nurses and their elderly clients perceive trusting relationships differently. Nurses' trust of their clients is expressed in terms of (a) respect, (b) compliance or noncompliance with what was negotiated, and (c) trust to express what is needed from the nurse. There were also a few examples of nurses not trusting their clients. Many elderly clients initially trust their nurses because nurses receive extensive education and work in the health care system. They believe that trust is essential to nurse-patient relationships and expect nurses to have a certain trust in them. Conversely, nurses feel that it is important for clients to trust them.

Nurses elaborated on the process of developing trusting relationships with their clients. Clients expressed the qualities they welcome in nurses, how they work with them, and how nurses help them. The overall theme which was identified in the data was labeled 'trusting, caring relationships.' The four phases in these relationship are (a) initial trusting, (b) connecting, (c) negotiating and (d) helping. Clients identified connecting as getting to know the nurse, and negotiating as working together. Nurses and clients used the term "helping".

Nurses and clients identified factors which can facilitate or interfere with the development of trusting relationships. These include the length of time in home care; having the same nurse; the identity of the initial nurse; the client's needs; the client's personality; the nurse's personality, skills, experience and priorities; the client's gender; the client's culture; the nurse's relationship with the physician; other services; and referral to home care.

Some of the themes in this study are similar to those identified in other research. Morse' s (1990) work on commitment and involvement in nurse-patient relationships and Kristjanson & Chalmers' research on nurse-client interactions in community-based practice are two examples. The findings from this study have implications for nursing practice, administration and education. More nursing research needs to be done on trust in different contexts to assist all nurses in establishing therapeutic nurse-client relationships.

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Appendix A

Example of guiding open-ended questions that the clients were asked.

1. Describe the nurses that visit you.

2. Tell me about your experiences with home care.

3. Tell me about your relationship with the nurses.

4. Do you have trusting relationships with any of the nurses who care for you? Please tell me what these relationships are like.

5. Describe the factors that interfere with the development of trusting relationships.

6. Tell me about the factors that promote the development of trusting relationships.

Example of guiding open-ended questions that the nurses were asked.

1. Tell me about your experiences with new referrals.

2. Describe your relationships with your clients.

3. Do you have trusting relationships with any of your clients? If so, please tell me about these trusting relationships.

4. Tell me about the factors that promote the development of trusting relationships.

5. Describe the factors that interfere with the development of trusting relationships.

Appendix B

Informed Consent for Clients

Title of Research- Developing Trusting Relationships: Home Care Nurses and Elderly Clients

Researcher
Lorraine Trojan
Master of Nursing Candidate
Faculty of Nursing
University of Nursing
phone 988-9293

Advisor
Dr. Olive Yonge
Associate Professor
Faculty of Nursing
University of Alberta
phone: 492-2402

Purpose of the Study:

The purpose of this study is to discover how trusting relationships develop between home care nurses and elderly clients. Also, the factors that help or stop the growth of these relationships will be studied.

Procedures

The researcher will interview you about your feelings and thoughts about this relationship. These interviews will be taped. There may be 1 to 3 interviews, with each one lasting about one hour. The interviews will take place at a time that is convenient to you. Your taped interview will get a number. Only the researcher will know your number. Your name, address and the nurses' names will be erased from the tape. Your number, name, address, and phone number will be kept in a locked cupboard and will be destroyed after the study is finished. The secretary will also be required to take an oath so that she or he will not tell anyone your name. The tapes will be kept in a locked cupboard. If the tapes are used for another study in the future, approval from an ethics committee will be obtained at that time. Your name will not be mentioned in any of the reports, articles or talks dealing with this study.

Participation

You do not have to be in this study if you do not want to be. If you want to leave the study at any time, just let the researcher know. You can also refuse to answer any questions . Your care will not be affected by being or not being in this study. If you mention any health problems which your nurse is not aware of, I will tell your nurse about them. I will also tell you if I am going to talk to your nurse about any of your health problems.

Risks

There are no known risks to you for being in this study. You, also, may not benefit directly from the study. However, it is hoped that in the future nursing care may be based on the findings from this study.

If you have any concerns or questions at any time, feel free to contact the researcher, Lorraine Trojan, at 988-9293

Consent

I, _____ have read this information, and agree to be in this study called 'Developing Trusting Relationships: Home Care Nurses and Elderly Clients.' I have had the chance to ask questions, and all my questions have been answered at this time by the researcher. I also agree to let the tapes from my interviews be used in future research as long as prior approval from an ethics committee is received for the study.

_____	_____	_____	_____
Researcher	Date	Signature	Date

If you would like to review the report from this study, please print your address on the space provided below:

_____

Appendix C

Informed Consents for Home Care Nurses

Title of Research- Developing Trusting Relationships: Home Care Nurses and Elderly Clients

Researcher
Lorraine Trojan
Master of Nursing Candidate
Faculty of Nursing
University of Alberta
phone: 988-9293

Advisor
Dr. Olive Yonge
Associate Professor
Faculty of Nursing
University of Alberta
phone: 492-2402

Purpose of the Study

The purpose of this study is to discover how trusting relationships develop between home care nurses and elderly clients. Also, the factors that interfere with or promote the development of these relationships will also be examined.

Procedures and Confidentiality

Tape-recorded interviews will be used to record your experiences, feelings and thoughts about this relationship. There may be 1 to 3 interviews, with each one lasting about one hour. These interviews will held at a time that is convenient to you. Your taped interview will get coded, and all the information identifying you will be erased from the tape. Only the researcher will know your code. Your number, name, address, and phone numbers will be kept in a locked cabinet and will be destroyed after the study is completed. The secretary will also be required to take an oath of confidentiality to provide extra protection. The tapes will be kept in a locked cabinet. If the tapes are used for secondary analysis in a future study, approval will be obtained from an ethics committee at that time. Your name will not be mentioned in any of the reports, articles or talks dealing with this study.

Voluntary Participation

You do not have to participate in this study if you do not want to. If you want to withdraw from the study at any time, just let the researcher know. You can also refuse to answer any questions. Your job will not be affected if you participate or withdraw from this study.

Risks

There are no known risks to you for participating in this study. You, also, may not benefit directly from the study. However, it is hoped that in the future nursing interventions may be based on the finding from this study.

If you have any concerns or questions at any time, feel free to contact the researcher, Lorraine Trojan, at 988-9293.

Consent

I, _____ have read this information, and agree to be in this study called 'Developing Trusting Relationships: Home Care Nurses and Elderly Clients.' I have had the opportunity to ask questions, and all my questions have been answered at this time by the researcher. I also agree to let the tapes from my interviews be used in future research as long as prior approval from an ethics committee is received for the study.

_____	_____	_____	_____
Researcher	Date	Signature	Date

If you would like to review the results from this study, please print your address on the space provided below.

_____

Appendix D

Oath of Confidentiality

Title of Research - Developing Trusting Relationships: Home Care Nurses and Their Clients

Investigator: Lorraine Trojan, RN, MN Candidate

Since this study involves confidential information, individuals working on this study are asked to sign an Oath of Confidentiality so there is adherence to this matter. A breach of confidentiality would make you legally responsible for any damages. By signing this oath you indicate that you are committed to keeping the information confidential.

I, _____, swear (or Solemnly affirm) that I will diligently, faithfuliy and to the best of my ability, execute according to law the duties required of me as an associate of this project known as Developing Trusting Relationships: Home Care Nurses and Elderly Clients. I will not, without undue authorization, disclose or make known any matter or thing which comes to my knowledge by reasons of my involvement in the service of this project.

_____
(signature)

Taken and subscribed before me at _____

this _____ day of _____, A.D. _____

_____
(witness)

Appendix E

Biographical Data : Clients
Year of birth?
Country of Birth?
Marital Status?
Reason for home care?
Date that home care services were initiated?
Number of nurses that you see routinely?
Do you see other health professionals?

Biographical Information: Nurses
Year of birth?
Nursing Education?
How long have you been employed as a nurse?